COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU
QUALITY IMPROVEMENT DIVISION

QUALITY IMPROVEMENT WORK PLAN EVALUATION REPORT
CALENDAR YEAR 2012

and

QUALITY IMPROVEMENT WORK PLAN
CALENDAR YEAR 2013

Marvin J Southard, D.S.W
Director

February 2013

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PROGRAM SUPPORT BUREAU
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Executive Summary

March 2013

Marvin J. Southard, D.S.W.
Director

The Quality Improvement Annual Work Plan is organized into six (6) major domains: Service Delivery Capacity, Accessibility of Services, Beneficiary Satisfaction, Clinical Care, Continuity of Care, and Provider Appeals. Each domain is designed to address mental health service needs and the quality of services provided. The Quality Improvement Program is a consumer focused program dedicated to fostering culturally competent services and improving access to underserved populations.

The total population of the County of Los Angeles is 9,866,194 and is one of the most ethnically diverse in the nation. The population by ethnicity is: Latinos at 48.0%, Whites at 29.0%, Asian and Pacific Islanders at 14.2%, African Americans at 8.6%, and Native Americans at 0.2%. The population by age group is: Adults at 47.6%, Older Adults at 16.2%, Transition Aged Youth at 15.2%, and Children at 21.0%. During FY 2011-2012, the Department provided mental health services in eight Service Areas to approximately 185,635 consumers in outpatient Short Doyle/Medi-Cal facilities.

In 2012 LACDMH collaborated with the UCLA, Integrated Substance Abuse Programs (ISAP) to pilot an abbreviated (7-item) version of the MHSIP Consumer Outcomes Survey. In February 2012, this 7 item survey was utilized as the County Performance Outcome Survey. The goals of this initiative are to allow LACDMH to transition to a new and meaningful data collection methodology ensuring randomized representative sampling, a cost-effective and user friendly form, and the maintenance of trend analyses. Enhanced statistical analyses were conducted on the effectiveness of this abbreviated survey and are presented in this report. These results will be used by the Department to guide ongoing quality improvement activities.

This report provides an overview of the QI Program, a description of the Departmental QI initiatives, including those for care integration. It includes detailed demographics and estimated populations with analyses of unmet need for services within each Service Area, using prevalence rates from the California Department of Health Care Services (CDHCS) and the California Health Interview Survey (CHIS). The report details progress made in achieving the 2012 QI Work Plan Goals and contains a description of the QI Work Plan goals for CY 2013.

Departmental Bureaus and Divisions including the Emergency Outreach Bureau, Patient's Rights Office, Office of the Medical Director, ACCESS Center, Service Area Quality Improvement Committees, Under-Represented Ethnic Populations (UREP) Sub-Committees, and Cultural Competency Committee (CCC) have contributed to this report.

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COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

QUALITY IMPROVEMENT WORK PLAN EVALUATION FOR CALENDAR YEAR 2012
and
QUALITY IMPROVEMENT WORK PLAN FOR 2013

The County of Los Angeles Department of Mental Health (LACDMH) Vision of: "Partnering with clients, families and communities to create hope, wellness, and recovery" guides our commitment to providing accessible, timely, and high-quality culturally appropriate and linguistically integrated publicly-funded mental health services for the County of Los Angeles residents. Our focal goal is to serve hard-to-reach, underserved ethnic and low-income populations with mental health needs. To further enhance the quality and increase the capacity of our mental health services, we actively seek partnerships and maintain collaborations with consumers, family members, and under-served ethnic communities to continuously evaluate and build upon our programs application and effectiveness. Our critical goals center on measurable and replicable outcomes, continuous quality improvement processes, assessment of efficacious evidence-based treatments in community settings, and overall enhancement of consumer satisfaction. All of this is in pursuit of an accessibly efficient and effective service delivery system for public mental health.

The size and cultural diversity of the County of Los Angeles present enormous challenges for serving our communities with quality, culturally relevant, and effective services. We embrace the cultural diversity of the communities we serve and work diligently to identify, describe and address disparities by providing culturally and linguistically appropriate services. We strive for an integrated model of health that encompasses mental health, physical health, and substance abuse services. We provide services in at least thirteen threshold languages and continue utilizing the Mental Health Services Act (MHSA) to further transform our system of care. We collaborate with diverse stakeholders to ensure that our services are culturally competent and effective. The Department's mission statement is: "Enriching lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency." The LACDMH values of "Integrity, Respect, Accountability, Collaboration, Dedication, Transparency, Quality and Excellence" form the foundation for constructing and improving client quality of life in the communities in which they live, work and learn.

It is important to emphasize that over the years the goals of the "Presidents New Freedom Commission on Mental Health – Transforming Mental Health Care in America" (July 2003), the Institute of Medicine's (IOM's) "Crossing the Chasm", and the SAMHSA/CMHS, NASMHPD Research Institute (NRI) National Outcome Measures (NOM's) have served to guide the department's direction and selection of Performance Outcomes and goals for improved quality. This national

perspective has provided a valuable framework for transformation of our system of care through measurable indicators that were identified by consumers and other stakeholders throughout the nation as having universal meaning and significance for improving the lives of the persons with mental health needs that we seek to serve.

This report is completed in compliance with the Mental Health Plan reporting requirements of the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.440, concerning Quality Improvement.

SECTION 1

QUALITY IMPROVEMENT PROGRAM DESCRIPTION

Quality Improvement Program Structure

The Quality Improvement Division (QID) is under the administration and direction of the Program Support Bureau (PSB), Deputy Director. Within the structure of the Program Support Bureau, the QID is charged with improving the accessibility and quality of system wide mental health services provided to eligible consumers and families. The Countywide Quality Improvement (QI) Program is guided by strategic Quality Improvement Work Plan goals and corresponding performance management activities. The QID monitors the Department's QI Program activities for effectiveness using national strategies and standards to organize, implement, and evaluate applied contributions that lead to improved quality of care and reduced disparities.

The structure and processes of the QI Program are defined in the Department's Policy and Procedure 105.1, Quality Improvement Program Policy, to ensure that the quality and accessibility of mental health services meets and exceeds local, State, and Federal requirements. The QI Program is organized and implemented in support of uniform QI functions, responsibilities and oversight for both the directly operated and contracted providers of the County's public mental health services system. The QI Program focuses on an organizational culture of continuous quality improvement that fosters wellness and recovery; reduces disparities; promotes consumer and family involvement; improves cultural competency; and integrates mental health and substance use co-occurring treatment services with physical health needs.

The QID includes the following three (3) Units: Cultural Competency (CC) Unit, the Data Geographic Information System (GIS) Unit, and Under-Represented Ethnic Populations (UREP)/Innovation (INN) Unit. The CC Unit is responsible for integrating culturally appropriate and sensitive practices through out the mental health system of care. The CC Unit also provides technical assistance and training necessary to fully integrate cultural competency into LACDMH operations. The Data GIS Unit is responsible for data collection, analysis, and reporting LACDMH demographic and clinical data. The Data GIS Unit is also responsible for the assessment of geographic distribution of mental health services. The UREP/INN Unit has responsibility for implementing one-time funding projects to build capacity and increase access for under-represented populations in our system of care: African/African American, American Indian/Alaskan Native, Asian Pacific Islander, Eastern-European/Middle Eastern, and Latino. The UREP/INN Unit is also implementing the Community Integrated Service Management Model (ISM) which promotes the establishment of networks of care that include formal providers, non-traditional healers, and community-based organizations to integrate health, mental health, and substance abuse for the five under-represented ethnic populations.

The areas of QI performance measurement, monitoring and management that are addressed in the QI Work Plan include: Capacity, accessibility, timeliness, quality, cultural competency, consumer and family satisfaction. Data analysis is used as a key tool for decision making, monitoring change and performance management to improve services and the quality of care. QI Work Groups are established as needed and QI Tools are implemented to facilitate the work of designated teams. Departmental Performance Improvement Projects (PIPs) are conducted to ensure that selected administrative and clinical processes are studied to improve performance outcomes. The QID and Data GIS Unit also coordinate with the Department's Bureaus, Divisions and Units directly responsible for conducting related QI activities and include the: Quality Assurance Division; ACCESS Center; Patient Rights Office; Office of STATS and Informatics; Service Area QI Committees and Multidisciplinary PIP Teams.

The Departmental Countywide Quality Improvement Council (QIC) is chaired by the QID Mental Health Clinical District Chief. It is Co-Chaired by a Regional Medical Director from the Office of the Medical Director. The QID District Chief also participates on the Southern California QIC, the Statewide QIC, and the LACDMH Strategies for Total Accountability and Total Success (STATS). The supervisor of the Cultural Competency Unit, which is a part of the Quality Improvement Division, is a standing member of the Departmental Countywide QIC and the Departmental Countywide Cultural Competency Committee (CCC).

The QI Program structure is formally integrated within several key levels of the service delivery system. The Departmental Countywide QIC meets monthly and consists of representation from each of the eight (8) Services Areas, Countywide DMH Programs and other QI stakeholders. At the Service Area level, all Service Areas have their own regular Service Area Quality Improvement Committee (SA QIC) meetings and the SA QIC Chairpersons are standing members of the Departmental Countywide QIC. Whenever possible, each Service Area has a Chairperson and Co-Chairperson or two Co-Chairpersons with one representing Directly Operated Providers and the other representing Contract Providers. The Quality Improvement Handbook, updated June 2010, is designed to be a reference for the QI structure and process providing guidelines for the functions and responsibilities of QIC members at all levels of participation.

At the provider level, all Directly Operated and Contracted Organizational Providers maintain their own Organizational QIC. In order to ensure that the QIC communication feedback loop is complete, all Service Area Organizational Providers are required to participate in their local SA QIC. This constitutes a structure supportive of effective communication between Providers and Service Area QICs, to the Quality Improvement Council, to the intended management structures and back through the system. Lastly, there is a communication loop between the SA QIC Chairperson and/or Co-Chairpersons and the respective Service Area District Chiefs and Service Area Advisory Committee (SAAC). The SAACs are comprised of consumers, family members, providers and the

LACDMH staff. The SAACs provide valuable information for program planning and opportunities for program and service improvement. SAACs are a centralized venue for improved consumer/family member participation at the SA QIC level.

The Cultural Competency Committee (CCC)
The CCC is led by two co-chairs elected annually by members of the Committee. The LACDMH Ethnic Services Manager (ESM) is a member of the Departmental Countywide QIC and the CCC. The LACDMH ESM is also the supervisor for the Cultural Competency Unit. This structure facilitates communication and collaboration for attaining the goals as set forth in the Departmental QI Work Plan and the Cultural Competency Plan to reduce disparities, increase capacity, and improve services. Additionally, relevant CCC decisions and activities are reported to the membership at each Departmental QIC meeting.

The Committee holds an annual meeting at the end of each calendar year to review accomplishments and vote on organizational cultural competency objectives to be undertaken for the next year. As an example, for 2012, the Committee formed three (3) workgroups: 1) E-news publications on Cultural Competency, 2) Revision of selected LACDMH policies and procedures (P&P's), and 3) Inclusion of Cultural Competency ratings in the evaluation forms used for instructor-led trainings. The E-news Workgroup generated four (4) articles for publication: Cambodian New Year, the Dymally Alatorre Bilingual Services Act, and CCC co-chairs. The fourth article, written on Cultural Competency as an evolving clinical framework, was adopted by the CCC as a concept paper and placed on the Cultural Competency Webpage. The P&P Workgroup revised two (2) existing policies: P&P 602.01 – Bilingual Bonus and P&P 202.21 – Language Interpreters. The revisions were reviewed and approved by the Program Support Bureau (PSB) Deputy Director and have been submitted to the Compliance Program Audit Services Bureau. Additionally, the CCC reviewed a new policy draft for Language Translation Services drafted by the Cultural Competency Unit and approved by the QID District Chief. This draft will be submitted to the PSB's Deputy Director for review and approval. Lastly, the Training Evaluations Workgroup ensured that LACDMH mandatory and elective instructor-led training evaluation forms include items that evaluate the cultural competency content.

Quality Improvement Program Processes
The ultimate purpose for the design, implementation, and evaluation of the QI Program is to ensure an organizational culture of continuous self-monitoring and self-correcting quality improvement through effective strategies, best practices, and activities, at all levels of the system.

Every year, the QID works in close collaboration with DMH staff to develop and/or revise measureable QI Work Plan goals and evaluate performance management activities. The QI Work Plan is reassessed at least annually to produce the QI Work Plan Evaluation Report and to develop and/or revise the

measureable QI Work Plan goals for the following year. Most typically, dynamic processes occur continuously throughout the year guided by collected and analyzed data that require further collaboration, such as with Integrated Systems (IS) staff for data accuracy or the Cultural Competency Unit for interpreting policy or performance management. The QI Work Plan and QI Evaluation processes can be categorized into six (6) main categories of State and Federal requirements to include: Service Delivery Capacity, Service Accessibility, Beneficiary Satisfaction, Clinical Issues, Continuity of Care and Provider Appeals.

The QID is also responsible for the formal reporting on the effectiveness of QI processes through the development and completion of the State and County Performance Outcomes Report. The County Outcomes which reflect QI measures were initiated in January 2008 at the request of the County of Los Angeles Board of Supervisors and reflect three critical domains of importance to our system. These domains are *Access to Services*, *Consumer/Family Satisfaction* and *Clinical Effectiveness*. The performance measures were selected by a representative group of stakeholders and the methodology is described in detail in the QI State & County Performance Outcomes Report dated August 2009. The report may be found online at http://psbqi.dmh.lacounty.gov/data.htm.

The Departmental Countywide QIC systematically and formally exchanges quality improvement information, data, and performance updates on QI goals and Performance Improvement Projects. These communications are documented in QI meeting minutes, website postings, and oversight reports, as appropriate. The QI Division staff prepares updates for goal targets through Quality Improvement Work Plan Implementation Status Reports that are discussed and distributed at the Departmental QIC Meetings. These QI Reports are also shared within the SA QIC Meetings. The QI Work Plan Implementation Status Reports may be found online at http://psbqi.dmh.lacounty.gov/QI.htm. The Departmental QI Program also engages and supports the SA QICs in QI processes related to the QI Work Plan, specific PIP activities, and other QI projects conducted at the SA level. In turn, SA QICs provide a structured forum for the identification of QI opportunities that are designed specifically to address the challenges and barriers encountered at the SA level and that may exist as a priority within the SA. SA QICs also engage and support Organizational QICs that are focused on their internal Organizational QI Programs and activities. The Organizational QICs conduct internal monitoring to ensure performance standards are met consistent with Quality Assurance and Quality Improvement standards. This includes activities such as: Client record reviews, identifying clinical issues, and client service satisfaction surveys.

QID Unit Program Descriptions

The QID Under-Represented Ethnic Populations (UREP)/Innovation (INN) Unit

One of the cornerstones of the Mental Health Services Act is to empower under-represented ethnic populations (UREP). During the planning phase of MHSA, a UREP Work Group, consisting of 56 culturally diverse mental health professionals and community and client advocates, was created to make implementation recommendations to LACDMH. This workgroup met extensively to develop guiding principles and recommendations for LACDMH as well as MHSA services. These recommendations were instrumental in establishing the Department's MHSA values and strategies in working with under-represented ethnic groups. In June, 2007, the Department established an internal UREP Unit within the Planning, Outreach and Engagement Division to address the ongoing needs of targeted ethnic and cultural groups. The UREP Unit has established sub-committees dedicated to working with the various under-represented ethnic populations in order to address their individual needs. These sub-committees are: African/African American; American Indian; Asian/Pacific Islander; Eastern European/Middle Eastern and Latino. In March 2012, the UREP/INN Unit was transitioned to the QI Division.

Each UREP sub-committee was allotted one-time funding totaling $620,000 to focus on Community Services and Supports (CSS) based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals were created and submitted via a participatory and consensus-based approach. The following are the projects implemented:

Latino – "Training for and Services Provided by Promotores de Salud" (February, 2011-December, 2012) to increase the capacity of the public mental health system to deliver best practice recovery-oriented outreach, engagement and linkage, and self-help groups by Promotores who have received mental health training and are culturally and linguistically competent in serving the needs of the Latino community.

Native American/Alaskan Native – LACDMH participated in Statewide Learning Collaboratives designed to develop innovative responses to budget shortfalls and increasing demand for services. The LACDMH Learning Collaborative explored the concept of community from strategic, administrative, geographic, and planning perspectives. Part of the funding was also utilized to fund an American Indian Mental Health Conference in November, 2012 entitled, "Weaving Wellness Into Our Spirits".

African/African American – 1) <u>Resource Mapping Project:</u> Funds were allocated to identify and map leaders, resources, and agencies in Service Area 6 where there is a large African/African American population to assist in

outreaching to and working with African and African American communities. 2) Culturally Competent Brochures: Materials used to outreach and engage underserved, inappropriately served and hard to reach ethnic communities. The purpose is to educate and inform these ethnically diverse communities to reduce stigma, provide mental health education and information about programs offered. The MHSA brochure will be translated into 5 different African languages including Amharic, Swahili, Ibo, Yoruba and Somali.

Eastern-European/Middle-Eastern – This project will produce culturally competent materials with which to outreach and engage underserved, and hard-to-reach families. The purpose is to educate and inform these ethnically diverse communities about the MHSA and when and how to access services. A brochure on mental health has been created and translated into 4 threshold languages (Arabic, Armenian, Farsi and Russian). The project includes promotional items such as pens, totes, magnets and posters. All brochures and promotional items include the 24/7 Toll Free ACCESS number for mental health services.

Asian Pacific-Islander – Development of a working API Consumer Leadership Council representing diverse interests throughout the County of Los Angeles. This project includes: 1) community outreach; 2) multi-lingual and multi-cultural approaches to engage a diversity of API mental health consumers; and 3) education and training sessions including 'Advocacy 101', 'Empowerment', 'Speaker's Training' and 'Friends and Loved Ones'. Through these efforts, our goal is to create new API Leadership Councils that reflect the diverse needs of our target populations, i.e. East Asian, Southeast Asian, South Asian and Pacific Islander groups. Services will be provided countywide.

On February 18, 2009, the County of Los Angeles MHSA Stakeholder Delegates, a countywide, diverse, and representative group specifically created to ensure wide and meaningful public participation in ongoing MHSA planning, endorsed a process that would prioritize three populations greatly impacted by the above issues – UREP, the uninsured, and homeless persons. From 105 strategies that were reviewed, the UREP workgroup brought forth the Community-Designed Integrated Service Management Model (ISM). Currently under implementation, the 14 ISMs target the following ethnic communities: African; African American; American Indian; Armenian; Cambodian; Chinese; Iranian; Korean; Latino and Samoan.

The ISM seeks to increase the quality of services by addressing the fragmentation inherent in the current system of care by building on the strengths of communities. This model envisions a model of care that is defined by the community itself and also promotes collaboration and partnerships between formal and non-traditional service providers, and community-based organizations to integrate physical health, mental health, substance abuse, and other needed care to support the recovery of consumers. In the ISM model, "formal" providers

are those that are traditionally recognized and funded through public and private insurance. “Non-traditional” providers are individuals who offer community-defined healing practices but do not have credentials that permit reimbursement from public or private insurance.

The ISM enhances the resources of the formal network of regulatory providers (e.g. mental health, health, substance abuse, child welfare, and other formal service providers) with culturally-effective principles and values. Services are grounded in ethnic communities with a strong foundation of community-based, non-traditional, and natural support systems such as faith-based organizations, voluntary associations, and other service groups. In this model, ISM teams are integrated through: 1) community designed peer-based outreach and education; 2) community-designed peer-based enhanced engagement practices; 3) community-designed peer-based enhanced linkage and advocacy; and 4) harmonious intertwining of regulatory and non-traditional services and supports through facilitation of inter-provider communication.

The QID Cultural Competency Unit

Cultural competency is a cross-cutting transformative principle. The Cultural Competency Unit (CCU) is under the direction of the QID. This organizational strategy allows for cultural competency to be integrated into QID roles and responsibilities to systematically improve services and accountability to our consumers, their family members, and the communities we serve. Additionally, it enables cultural competency efforts, such as the implementation of the State’s Cultural Competency Plan Requirements, to be at the forefront of our service planning and delivery.

The LACDMH Cultural Competency Plan identifies the following 19 strategies to reduce disparities, especially those due to race, ethnicity and culture:

1. Outreach and Engagement
2. Community education to increase mental health awareness and decrease stigma
3. Multi-lingual/multicultural materials
4. Collaboration with faith-based and other trusted community entities/groups
5. School-based services
6. Field-based services
7. Programs that target specific ethnic and language groups
8. Designating and tracking ethnic targets for FSP

9. Flexibility in FSP enrollment such as allowing “those living with family” to qualify as “at-risk of homelessness”

10. Countywide FSP Networks to increase linguistic/cultural access

11. Integrated Supportive Services

12. Co-location with other county departments (DCFS, DPSS, DHS)

13. Interagency Collaboration

14. Consultation to gatekeepers

15. Trainings/ case consultation

16. Provider communication and support

17. Multi-lingual/multi-cultural staff development and support

18. Evidence Based Practices/Community-Defined Practices for ethnic populations

19. Investments in learning (e.g. Innovation Plan)

Collectively, these 19 strategies serve to organize our efforts to reduce disparities; combat stigma; promote hope, wellness, recovery and resiliency; and serve our communities with quality, timely, accessible and integrated services.

The QID Data GIS Unit

The Data GIS Unit is responsible for calculating system wide information on consumers served and estimating populations in need of mental health services. The Data GIS Unit annually calculates the population estimated with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI), and penetration and retention rates by all demographic categories: Age, gender, ethnicity and primary language. Trend analysis is conducted on these data to assess fluctuations in service utilization and service delivery capacity. The Prevalence, Penetration and Retention Rates are also calculated for the eight (8) Service Areas for dissemination to the respective District Chiefs and Quality Improvement Liaisons for Quality Improvement Projects and Performance Improvement Projects, as appropriate.

Mental Health Service Utilization Rates are also calculated by census tracts to conduct spatial analysis to estimate geographic gaps in services. This information is used to estimate service delivery capacity and set targets for meeting the needs of underserved populations.

The Data GIS Unit also maintains and updates the LACDMH Provider List of Specialty Mental Health Services. The provider list has information on age

groups served, contact information, hours of operation and Specialty Mental Health Services provided at each service location to enable consumers and the public to find appropriate mental health services in the County of Los Angeles. The provider list is disseminated as a hard copy annually to Service Area providers as the annual Provider Directory for the use by consumers, consumer family members, provider staff and other stakeholders. The provider list is also maintained online as a searchable web application. All the data and GIS applications developed and maintained by the Data GIS Unit are available online at http://psbqi.dmh.lacounty.gov

Integrated Primary Care, Mental Health Care, and Substance Abuse Care Services - Healthy Way LA (HWLA)

In collaboration with the Department of Health Services (DHS), LACDMH has integrated primary care, mental health care, and substance abuse care services through implementation of the Low Income Health Program (LIHP) under the 1115 Waiver Demonstration Project. The 1115 Waiver Demonstration Project is a Medicaid Demonstration Project commonly known as California's Bridge to Reform between the Centers for Medicare and Medicaid Services (CMS) and the State of California. The 1115 Waiver Demonstration Project provides the framework to federal Health Care Reform in 2014 by permitting health care coverage expansion to individuals who will become eligible for full Medi-Cal benefits in 2014.

Mental health services are now a mandated component of the LIHP and are available to all individuals enrolled in Healthy Way LA who meet mental health medical necessity criteria. County of Los Angeles residents between the ages of 19-64 years old, childless or non-custodial parents, and persons or clients with income living at or below 133% Federal Poverty Level with a valid government issued identification and with proof of residence are eligible for enrollment into HWLA. On January 1, 2014, under new Federal health care reform eligibility criteria, it is anticipated that active members of HWLA will be automatically enrolled into Medi-Cal thus providing a bridge or seamless transition for low income members.

There are many reasons for delivering integrated primary and behavioral health care. Some of the most compelling reasons are that integrated care improves the health outcomes and life expectancy of our service population; integrated care decreases the per capita cost of healthcare; and integrated care enhances the quality of care provided to our clients.

Enrollment in HWLA is expected to continue to increase in the County of Los Angeles ultimately reaching between 130,000 and 150,000 adults by 2014. HWLA primary care services are delivered through a network of providers that include DHS directly operated hospitals, comprehensive health centers, and ambulatory care centers in addition to the geographically diverse system of Community Partner agencies. The mental health benefits are delivered through the existing and expanded network of LACDMH directly operated and contracted

specialty mental health clinics, providing culturally sensitive and linguistically appropriate services for HWLA enrollees.

Mental health care may be understood as being delivered in three "tiers". Tier 1 clients are the current LACDMH priority population and include persons with serious mental illness. Tier 2 clients are persons with acute mental illness seen in primary care settings that would benefit from short term treatment and early intervention. Tier 3 clients are persons seen in primary care settings who receive and desire psychiatric medication management only services provided by their primary care physician. HWLA new enrollees are primarily increasing the demand for Tier 2 mental health care services.

HWLA stipulates that upon referral by the primary care provider, clients will be given an appointment for mental health service within 30 business days. Referral tracking and reporting is required monthly including the number of clients, preferred language, ethnicity, presenting problem, date of referral, date of initial appointment, and current status. Eligible clients are provided with short term mental health treatment up to 6 sessions within a 12-week period using the Mental Health Integration Program (MHIP). Three additional sessions may be obtained if necessary with an approved Treatment Authorization Request (TAR) for a maximum of 9 sessions within a 12 week period. MHIP is an evidence-based early intervention with demonstrated success in primary care – behavioral health integration. Procedures for referral to Tier 1 level of care are specified for use as necessary. The DMH Revenue Management Division (RMD) issues RMD Bulletins with instructions and information as necessary. A HWLA toolkit is available on the DMH website at: http://dmh.lacounty.gov/wps/portal/dmh

Since 2011, five (5) DHS facilities began making HWLA referrals to co-located DMH teams consisting of two (2) clinicians and one (1) medical caseworker, with at least one (1) Spanish-speaking clinician. Tracking of data, including referral timelines and initial appointments, ethnicity and age group, language and ethnicity, is providing an extensive data base that will be used to evaluate the performance of this program.

Summary

The evaluative report that follows assesses the performance outcomes identified in the County Quality Improvement Work Plan for Calendar Year 2012. The foundation for this evaluation is presented in the context of population demographics, both Countywide and by Service Area as well as other clinical and consumer satisfaction data, including trending data. Evaluation of the Quality Improvement Work Plan results in analytical findings that inform appropriate revisions to the set goals and objectives for the subsequent year.

SECTION 2

POPULATION NEEDS ASSESSMENT

The County of Los Angeles is the most populous county in the United States with an estimated population of 9,866,194 people in CY 2011. It consists of 88 legal cities or 18.3% of California's 482 cities and covers 4,057.9 square miles or 2.6% of all the land in the State of California.

In the County of Los Angeles, population density as measured by the number of people per square mile is 2,431 while the population density in the State of California is 238.

The Population by Ethnicity in the County of Los Angeles as shown in **Fig. 1** is the highest among Latinos at 48.0%, followed by Whites at 29.0%, Asian/Pacific Islanders (API) at 14.2%, African Americans at 8.6%, and Native Americans at 0.2%. This section contains estimated population data for the County of Los Angeles by Ethnicity, Age, and Gender collected by the US Census Bureau for the Decennial Census conducted in 2010.

Methods

This section reports on data by calendar year for population and living at or below 200% Federal Poverty Level (FPL), and by fiscal year for Medi-Cal eligible population and consumers served. All the data is reported by each Service Area (SA).

Statistical analyses were conducted to test for SA differences for overall population, living at or below 200% FPL, Medi-Cal eligible population and consumers served. Due to the high overall sample size, and smaller distribution of some categories within each SA, such as Native American or Older Adult populations, all chi-square statistics for data between SAs is statistically significant. Therefore it is not reported in each table. For additional information on SA differences, further analysis needs to be conducted separately within each SA.

The data include: Estimated Prevalence by age group for Serious Emotional Disturbance (SED) in Children and Youth and Serious Mental Illness (SMI) in Adults and Older Adults among the Total Population; Estimated Prevalence of persons with SED and SMI by Ethnicity and Gender; Estimated Population Living At or Below 200% FPL; and, Estimated Prevalence of persons with SED and SMI Living At or Below 200% FPL. These data sets together with demographic County Medi-Cal Enrollment Rates and demographic data for Consumers Served by the LACDMH provide a basic foundation for estimating target population needs.

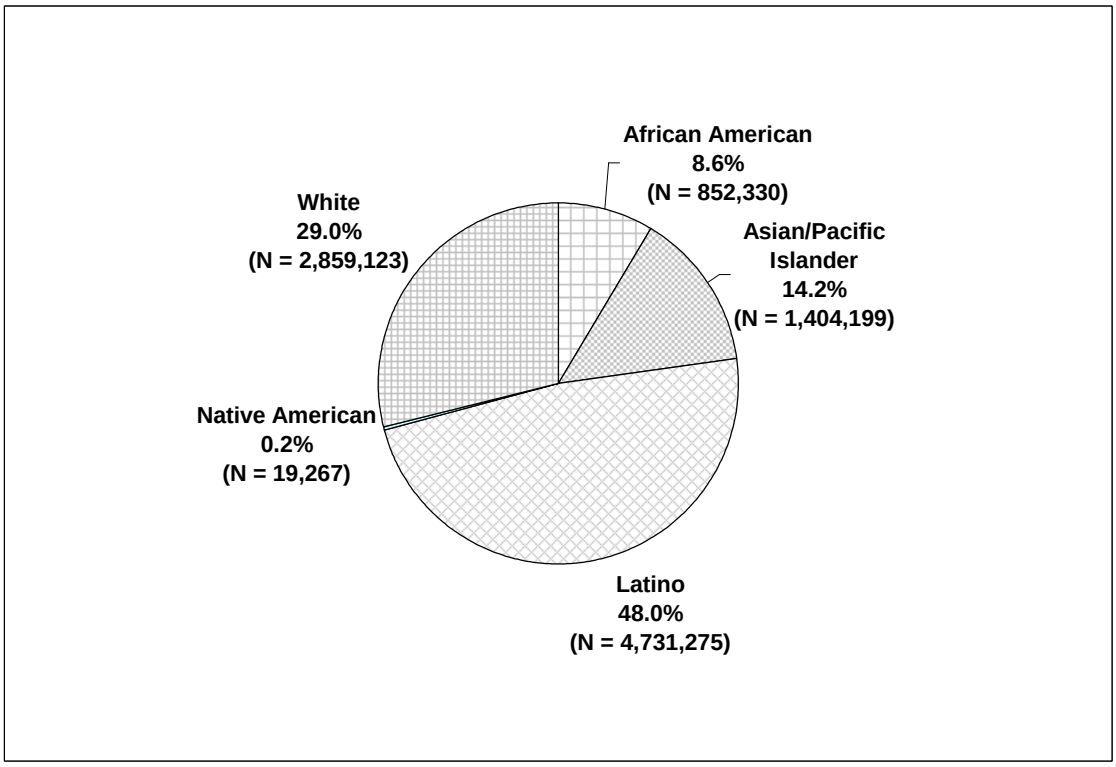
The Service Area Estimated Prevalence Rates for persons with SED and SMI are derived by using Countywide Estimated Prevalence Rates as established and provided by the California Department of Health Care Services (CDHCS) and the California Health Interview Survey (CHIS), and are shown in the Tables and Figures of this report. Penetration Rates for persons with SED and SMI are derived by using demographic data for Consumers Served as compared with the Estimated Prevalence Rates as shown in the Tables and Figures of this report. Taken altogether and in consideration of other pertinent variables, this data composite is helpful in understanding and estimating target population needs.

The use of trending analysis is another means to further understand and assess target population needs. Capturing directional change over time and testing for significance are important steps in the evaluation of performance and to ensure appropriate future planning and decision making. As such, trending data and tables are also included in this report as appropriate for selected performance measures.

Additionally, the 1115 Waiver initiated in 2011 and implemented throughout 2012 provides funding that expands the provision of mental health services to currently non-eligible Medi-Cal adults living at or below the 133% FPL that meet the required enrollment eligibility criteria. The impact of Healthcare Reform, and the 133% FPL expansion of services from the 100% FPL, is significant for the enhanced provision of integrated physical health, mental health, and substance abuse services. To more accurately assess demographic and geographic population needs, the 133% FPL data is computed in a separate detailed report, produced by the LACDMH Program Support Bureau, Quality Improvement Division. This supplemental report is the “Demographic Needs Assessment Report.”

Total Population

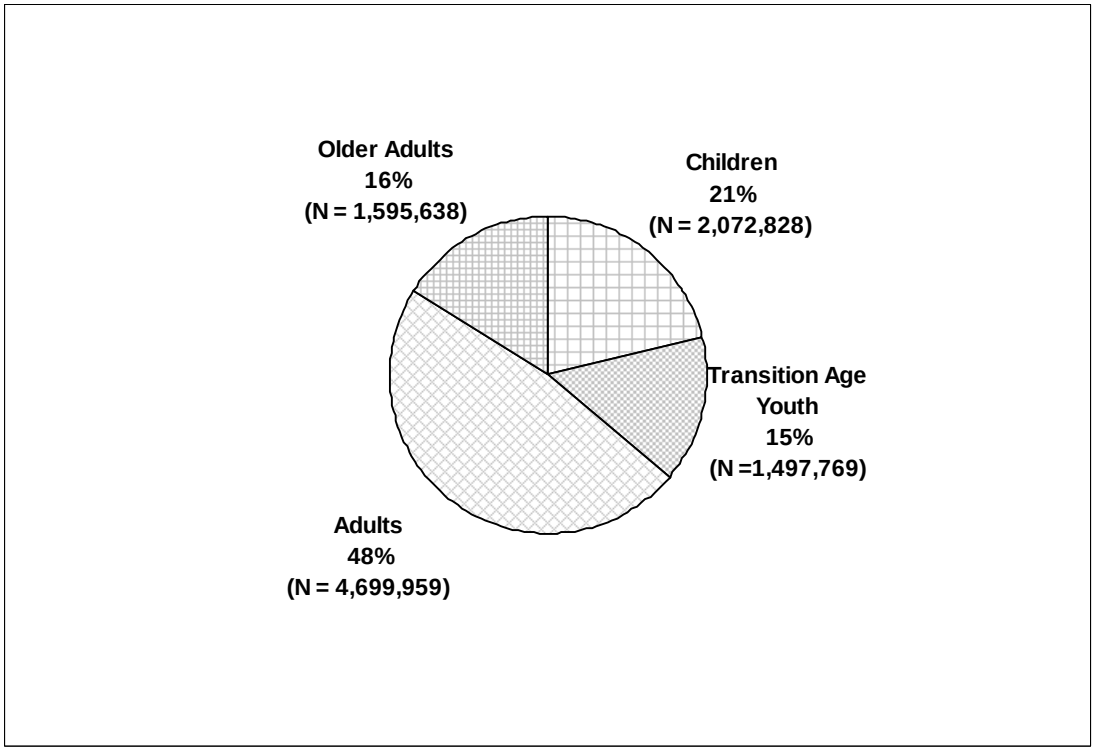
FIGURE 1: POPULATION BY ETHNICITY
CY 2011 (N = 9,866,194)



Data Source: US Census Bureau, 2011

Figure 1 shows Population by Ethnicity is highest among Latinos at 48.0%, followed by Whites at 29.0%, Asian/Pacific Islanders (API) at 14.2%, African Americans at 8.6%, and Native Americans at 0.2%.

FIGURE 2: POPULATION BY AGE GROUP
CY 2011 (N = 9,866,194)



Data Source: US Census Bureau, 2011

Figure 2 shows Population by Age Group is highest among Adults at 48%, followed by Children at 21%, Older Adults at 16%, and Transition Aged Youth (TAY) at 15%.

TABLE 1: POPULATION BY ETHNICITY AND SERVICE AREA
CY 2011

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Service Area Total
SA 1	60,750	15,057	171,789	1,584	137,346	386,526
Percent	15.7%	3.9%	44.4%	**0.40%**	35.5%	**3.9%**
SA 2	75,422	239,962	839,273	3,889	978,035	2,136,581
Percent	3.5%	11.2%	39.3%	0.20%	45.8%	**21.7%**
SA 3	65,480	491,201	808,475	2,994	383,976	1,752,126
Percent	3.7%	**28.0%**	46.1%	0.20%	21.9%	17.8%
SA 4	60,937	197,997	578,307	2,106	280,744	1,120,091
Percent	5.4%	17.7%	51.6%	0.20%	25.1%	11.4%
SA 5	37,196	85,130	100,488	962	413,353	637,129
Percent	5.8%	13.4%	**15.8%**	0.20%	**64.9%**	6.5%
SA 6	286,761	18,349	676,026	1,448	24,602	1,007,186
Percent	**28.5%**	**1.8%**	67.1%	**0.10%**	**2.4%**	10.2%
SA 7	38,463	116,933	951,482	2,711	188,603	1,298,192
Percent	**3.0%**	9.0%	**73.3%**	0.20%	14.5%	13.2%
SA 8	227,321	239,570	605,435	3,573	452,464	1,528,363
Percent	14.9%	15.7%	39.6%	0.20%	29.6%	15.5%
Total	852,330	1,404,199	4,731,275	19,267	2,859,123	9,866,194
Percent	8.6%	14.2%	48.0%	.20%	29.0%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011.

Differences by Ethnicity

SA 6 at 28.5% has the highest percentage of African Americans as compared with the lowest percentage in SA 7 at 3.0%.

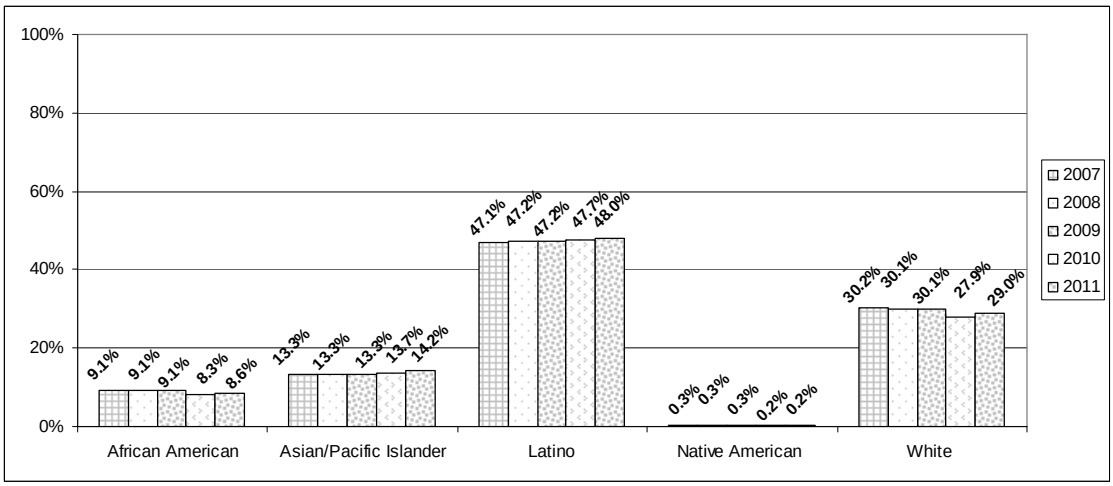
SA 3 at 28.0% has the highest percentage of Asian/Pacific Islanders (API) as compared with the lowest percentage in SA 6 at 1.8%.

SA 7 at 73.3% has the highest percentage of Latinos as compared with the lowest percentage in SA 5 at 15.8%.

SA 1 at 0.4% has the highest percentage of Native Americans as compared with the lowest percentage in SA 6 at 0.1%.

SA 5 at 64.9% has highest percentage of Whites as compared with the lowest percentage in SA 6 at 2.4%.

FIGURE 3: POPULATION PERCENT CHANGE BY ETHNICITY
CY 2007 - 2011



As the percentage of the total population, African Americans decreased by 0.5% from 9.1% in 2007 to 8.6% in 2011. In 2008 the African American population was at 9.1%, in 2009 it was at 8.3%, and in 2010 it was at 8.6%.

As the percentage of the total population, Asian/Pacific Islanders (API) increased by 0.9% from 13.3% in 2007 to 14.2% in 2011. In 2008 the API population was at 13.3%, in 2009 it was at 13.3, and in 2010 it was at 13.7%.

As the percentage of the total population, Latinos increased by 0.9% from 47.1% in 2007 to 48.0% in 2011. In 2008 the Latino population was at 47.2%, in 2009 it was at 47.2%, and in 2010 it was at 47.7%.

As the percentage of the total population, Native Americans decreased by 0.1% from 0.3% in 2007 to 0.2% in 2011. In 2008 the Native American population was at 0.3%, in 2009 it was at 0.3%, and in 2010 it was at 0.2%.

As the percentage of the total population, Whites decreased by 1.2% from 30.2% in 2007 to 29.0% in 2011. In 2008 the White population was at 30.1%, in 2009 it was at 30.1%, and in 2010 it was at 27.9%.

TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA
CY 2011

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60 + yrs	SA Total
SA 1	99,335	65,610	171,700	49,881	386,526
Percent	25.7%	17.0%	44.4%	12.9%	**3.9%**
SA 2	429,944	303,014	1,042,711	360,912	2,136,581
Percent	20.1%	**14.2%**	48.8%	16.9%	**21.7%**
SA 3	353,627	263,195	814,230	321,074	1,752,126
Percent	20.2%	15.0%	46.5%	18.3%	17.8%
SA 4	195,130	159,461	593,183	172,317	1,120,091
Percent	17.4%	**14.2%**	**53.0%**	15.4%	11.4%
SA 5	89,410	90,283	327,875	129,561	637,129
Percent	**14.0%**	**14.2%**	51.5%	**20.3%**	6.5%
SA 6	269,966	186,192	437,343	113,685	1,007,186
Percent	**26.8%**	**18.5%**	**43.4%**	**11.3%**	10.2%
SA 7	309,387	211,431	583,548	193,826	1,298,192
Percent	23.8%	16.3%	45.0%	14.9%	13.2%
SA 8	326,035	218,582	729,365	254,381	1,528,363
Percent	21.3%	14.4%	47.7%	16.6%	15.5%
Total	2,072,828	1,497,769	4,699,959	1,595,638	9,866,194
Percent	21.0%	15.2%	47.6%	16.2%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011.

Differences by Age Group

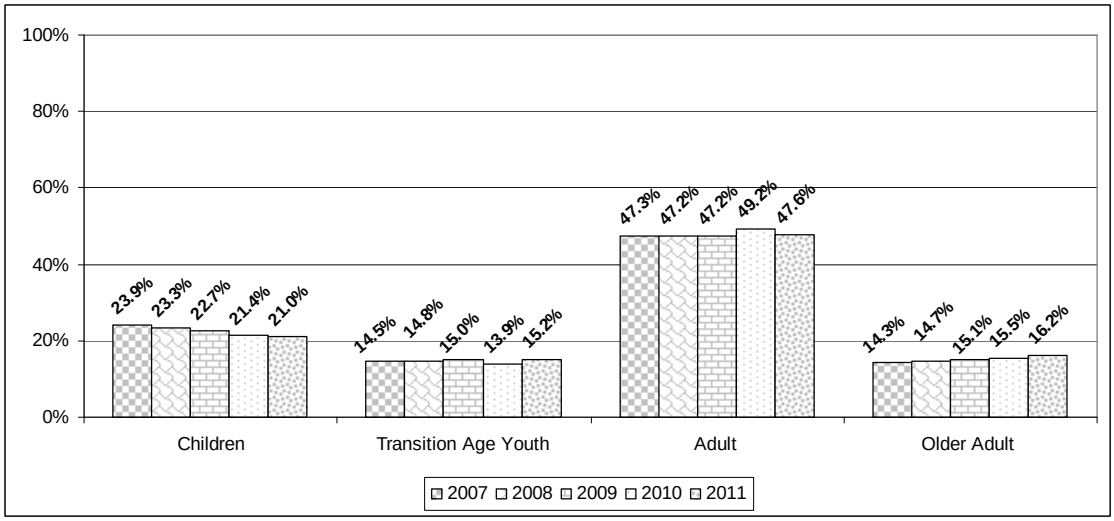
SA 1 at 26.8% has the highest percentage of Children as compared with the lowest percentage in SA 5 at 14.0%.

SA 6 at 18.5% has the highest percentage of TAY as compared with the lowest percentage in SASs 2, 4, and 5 at 14.2%.

SA 4 at 53.0% has the highest percentage of Adults as compared with the lowest percentage in SA 6 at 43.4%.

SA 5 at 20.3% has the highest percentage of Older Adults as compared with the lowest percentage in SA 6 at 11.3%.

FIGURE 4: POPULATION PERCENT CHANGE BY AGE GROUP
CY 2007 - 2011



As the percentage of the total population, Children decreased by 2.9% from 23.9% in 2007 to 21.0% in 2011. In 2008 the Child population was at 23.3%, in 2009 it was at 22.7%, and in 2010 it was at 21.4%.

As the percentage of the total population, TAY increased by 0.7% from 14.5% in 2007 to 15.2% in 2011. In 2008 the TAY population was at 14.8%, in 2009 it was at 15.0%, and in 2010 it was at 13.9%.

As the percentage of the total population, Adults increased by 0.3% from 47.3% in 2007 to 47.6% in 2011. In 2008 the Adult population was at 47.2%, in 2009 it was at 47.2%, and in 2010 it was at 49.2%.

As the percentage of the total population, Older Adults increased by 1.9% from 14.3% in 2007 to 16.2% in 2011. In 2008 the Older Adult population was at 14.7%, in 2009 it was at 15.1%, and in 2010 it was at 15.5%.

TABLE 3: POPULATION BY GENDER AND SERVICE AREA
CY 2011

Service Area (SA)	Male	Female	SA Total
SA 1	192,165	194,361	386,526
Percent	49.7%	50.3%	**3.9%**
SA 2	1,057,579	1,079,002	2,136,581
Percent	49.5%	50.5%	**21.7%**
SA 3	855,048	897,078	1,752,126
Percent	48.8%	51.2%	17.8%
SA 4	575,842	544,249	1,120,091
Percent	**51.4%**	**48.6%**	11.4%
SA 5	308,518	328,611	637,129
Percent	**48.4%**	**51.6%**	6.5%
SA 6	490,045	517,141	1,007,186
Percent	48.7%	51.3%	10.2%
SA 7	637,718	660,474	1,298,192
Percent	49.1%	50.9%	13.2%
SA 8	747,718	780,652	1,528,370
Percent	48.9%	51.1%	15.5%
Total	4,864,629	5,001,565	9,866,194
Percent	49.3%	50.7%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011.

Differences by Gender

SA 4 at 51.4% has the highest percentage of Males as compared with the lowest percentage in SA 5 at 48.4%.

SA 5 has the highest percentage of Females at 51.6% as compared with the lowest percentage in SA 4 at 48.6%.

Estimated Prevalence

TABLE 4: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG TOTAL POPULATION BY ETHNICITY AND SERVICE AREA CY 2011

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White
SA 1	4,435	1,099	12,541	116	10,026
Percent	15.7%	3.9%	44.5%	**0.40%**	35.5%
SA 2	5,506	17,517	61,267	284	71,397
Percent	3.5%	11.2%	39.3%	0.20%	45.8%
SA 3	4,780	35,858	59,019	219	28,030
Percent	3.7%	**28.0%**	46.2%	0.20%	21.9%
SA 4	4,448	14,454	42,216	154	20,494
Percent	5.4%	17.7%	51.6%	0.20%	25.1%
SA 5	2,715	6,214	7,336	70	30,175
Percent	5.8%	13.3%	**15.8%**	0.20%	**64.9%**
SA 6	20,934	1,339	49,350	106	1,796
Percent	**28.5%**	**1.8%**	67.2%	**0.10%**	**2.4%**
SA 7	2,808	8,536	69,458	198	13,768
Percent	**3.0%**	9.0%	**73.3%**	0.20%	14.5%
SA 8	16,594	17,489	44,197	261	33,030
Percent	14.9%	15.7%	39.6%	0.20%	29.6%
Total	62,220	102,506	345,384	1408	208,716
Percent	8.6%	14.2%	48.0%	.20%	29.0%

Note: Bold represents the highest and lowest percent in each group.
[1] SED = Serious Emotional Disturbance (Children), SMI = Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by the California Health Interview Survey (CHIS) for total population at 7.3%.

Differences by Ethnicity

SA 6 at 28.5% has the highest percentage of African Americans estimated with SED and SMI as compared with the lowest percentage in SA 7 at 3.0%.

SA 3 at 28.0% has the highest percentage of Asian/Pacific Islanders (API) estimated with SED and SMI as compared with the lowest percentage in SA 6 at 1.8%.

SA 7 at 73.3% has the highest percentage of Latinos estimated with SED and SMI as compared with the lowest percentage in SA 5 at 15.8%.

SA 1 at 0.4% has the highest percentage of Native Americans estimated with SED and SMI as compared with the lowest percentage in SA 6 at 0.1%.

SA 5 at 64.9% has highest percentage of Whites estimated with SED and SMI as compared with the lowest percentage in SA 6 at 2.4%.

TABLE 5: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG TOTAL POPULATION BY AGE GROUP AND SERVICE AREA CY 2011

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60 + yrs
SA 1	7,251	4,790	12,534	3,641
Percent	25.7%	17.0%	44.4%	12.9%
SA 2	31,386	22,120	76,118	26,347
Percent	20.1%	**14.2%**	48.8%	16.9%
SA 3	25,815	19,213	59,439	23,438
Percent	20.2%	15.0%	46.5%	18.3%
SA 4	14,244	11,641	43,302	12,579
Percent	17.4%	**14.2%**	**53.0%**	15.4%
SA 5	6,527	6,591	23,935	9,458
Percent	**14.0%**	**14.2%**	51.5%	**20.3%**
SA 6	19,708	13,592	31,926	8,299
Percent	**26.8%**	**18.5%**	**43.4%**	**11.3%**
SA 7	22,585	15,434	42,599	14,149
Percent	23.8%	16.3%	45.0%	14.9%
SA 8	23,801	15,956	53,244	18,570
Percent	21.3%	14.4%	47.7%	16.6%
Total	151,317	109,337	343,097	116,481
Percent	21.0%	15.2%	47.6%	16.2%

Note: Bold represents the highest and lowest percent in each group.
[1] SED = Serious Emotional Disturbance (Children), SMI = Serious Mental Illness (Adults).
Estimated prevalence rate of mental illness is provided by the California Health Interview Survey (CHIS) for total population at 7.3%.

Differences by Age Group

SA 6 at 26.8% has the highest percentage of Children estimated with SED as compared with the lowest percentage in SA 5 at 14.0%.

SA 6 at 18.5% has the highest percentage of TAY estimated with SED or SMI as compared with the lowest percentage in SAs 2, 4, and 5 at 14.2%.

SA 4 at 53.0% has the highest percentage of Adults estimated with SMI as compared with the lowest percentage in SA 6 at 43.4%.

SA 5 at 20.3% has the highest percentage of Older Adults estimated with SMI as compared with the lowest percentage in SA 6 at 11.3%.

TABLE 6: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG TOTAL POPULATION BY GENDER AND SERVICE AREA CY 2011

Service Area (SA)	Male	Female
SA 1	14,028	14,188
Percent	49.7%	50.3%
SA 2	77,203	78,767
Percent	49.5%	50.5%
SA 3	62,419	65,487
Percent	48.8%	51.2%
SA 4	42,036	39,730
Percent	**51.4%**	**48.6%**
SA 5	22,522	23,989
Percent	**48.4%**	**51.6%**
SA 6	35,773	37,751
Percent	48.7%	51.3%
SA 7	46,553	48,215
Percent	49.1%	50.9%
SA 8	54,583	56,988
Percent	48.9%	51.1%
Total	355,117	365,115
Percent	49.3%	50.7%

Note: Bold represents the highest and lowest percent in each group.
[1] SED = Serious Emotional Disturbance (Children), SMI = Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by the California Health Interview Survey (CHIS) for total population at 7.3%.

Differences by Gender

SA 4 at 51.4% has the highest percentage of Males estimated with SED and SMI as compared with the lowest percentage in SA 5 at 48.4%.

SA 5 at 51.6% has the highest percentage of Females estimated with SED and SMI as compared with the lowest percentage in SA 4 at 48.6%.

Estimated Population Living at or Below 200% Federal Poverty Level (FPL)

TABLE 7: ESTIMATED POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY AND SERVICE AREA CY 2011

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Service Area Total
SA 1	34,966	2,996	91,412	491	30,444	160,309
Percent	21.8%	1.9%	57.0%	**.30%**	19.0%	4.0%
SA 2	27,289	50,870	462,780	795	225,748	767,482
Percent	3.6%	6.6%	60.3%	**.10%**	29.4%	**19.0%**
SA 3	23,475	160,633	362,006	640	73,925	620,679
Percent	3.8%	**25.9%**	58.3%	**.10%**	11.9%	15.4%
SA 4	26,750	79,466	381,807	932	85,852	574,807
Percent	4.7%	13.8%	66.4%	.20%	14.9%	14.3%
SA 5	9,894	24,757	42,923	94	75,728	153,396
Percent	6.4%	16.1%	**28.0%**	**.10%**	**49.4%**	**3.8%**
SA 6	145,410	10,771	465,414	906	10,824	633,325
Percent	**23.0%**	**1.7%**	73.5%	**.10%**	**1.7%**	15.7%
SA 7	14,183	26,459	453,994	696	40,030	535,362
Percent	**2.6%**	4.9%	**84.8%**	**.10%**	7.6%	13.3%
SA 8	86,015	70,009	351,984	989	77,393	586,390
Percent	14.7%	11.9%	60.0%	.20%	13.2%	14.5%
Total	367,983	425,962	2,612,325	5,543	619,945	4,031,758
Percent	9.1%	10.6%	64.8%	.10%	15.4%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011. 2011 poverty estimates are imputed from 2010 poverty estimates.

Differences by Ethnicity

SA 6 at 23.0% has the highest percentage of African Americans living at or below 200% FPL as compared with the lowest percentage in SA 7 at 2.6%.

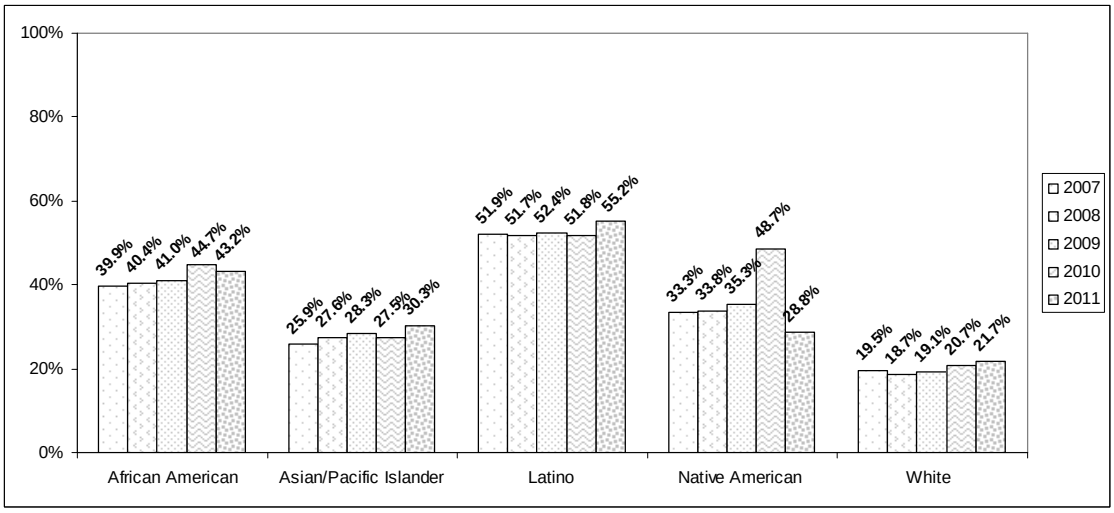
SA 3 at 25.9% has the highest percentage of Asian/Pacific Islanders (API) living at or below 200% FPL as compared with the lowest percentage in SA 6 at 1.7%.

SA 7 at 84.8% has the highest percentage of Latinos living at or below 200% FPL as compared with the lowest percentage in SA 5 at 28.0%.

SA 1 at 0.30% has the highest percentage of Native Americans living at or below 200% FPL as compared with the lowest percentage in SAs 2, 3, 5, 6, and 7 at 0.1%.

SA 5 at 49.4% has highest percentage of Whites living at or below 200% FPL as compared with the lowest percentage in SA 6 at 1.7%.

FIGURE 5: ESTIMATED POVERTY RATE CHANGE AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY CY 2007 - 2011



Note: Estimated Poverty Rate by Ethnicity = Total population living at or below 200% FPL divided by total population in each ethnic group.

As the percentage of the total population, African Americans living at or below the 200% FPL increased by 3.3% from 39.9% in 2007 to 43.2% in 2011. In 2008 the African American population living at or below 200% FPL was at 40.4%, in 2009 it was at 41.0%, and in 2010 it was at 44.7%.

As the percentage of the total population, Asian/Pacific Islanders (API) population living at or below the 200% FPL increased by 4.4% from 25.9% in 2007 to 30.3% in 2011. In 2008 the API population living at or below 200% FPL was at 27.6, in 2009 it was at 28.3%, and in 2010 it was at 27.5%.

As the percentage of the total population, Latinos living at or below the 200% FPL increased by 3.3% from 51.9% in 2007 to 55.2% in 2011. In 2008 the Latino population living at or below 200% FPL was at 51.7%, in 2009 it was at 52.4%, and in 2010 it was at 51.8%.

As the percentage of the total population, Native Americans living at or below the 200% FPL decreased by 4.5% from 33.3% in 2007 to 28.8% in 2011. In 2008 the Native American population living at or below 200% FPL was at 33.8%, in 2009 it was at 35.3%, and in 2010 it was at 48.7%.

As the percentage of the total population, Whites living at or below the 200% FPL increased by 2.2% from 19.5% in 2007 to 21.7% in 2011. In 2008 the White population living at or below 200% FPL was at 18.7%, in 2009 it was at 19.1%, and in 2010 it was at 20.7%.

TABLE 8: ESTIMATED POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA CY 2011

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60 + yrs	SA Total
SA 1	57,089	30,210	59,517	13,492	160,308
Percent	**35.6%**	18.8%	**37.2%**	8.4%	4.0%
SA 2	207,553	123,734	345,380	90,813	767,480
Percent	27.1%	16.1%	45.0%	11.8%	**19.0%**
SA 3	170,731	100,947	267,447	81,553	620,678
Percent	27.5%	16.3%	43.1%	**13.1%**	15.4%
SA 4	137,380	89,789	275,573	72,064	574,806
Percent	23.9%	**15.6%**	47.9%	12.6%	14.3%
SA 5	22,047	30,807	80,936	19,605	153,395
Percent	**14.3%**	**20.1%**	**52.8%**	12.8%	**3.8%**
SA 6	220,484	115,875	245,000	51,964	633,323
Percent	34.8%	18.3%	38.7%	**8.2%**	15.7%
SA 7	181,681	87,323	206,884	59,472	535,360
Percent	33.9%	16.3%	38.6%	11.2%	13.3%
SA 8	175,184	98,095	254,802	58,308	586,389
Percent	29.9%	16.7%	43.5%	9.9%	14.5%
Total	1,172,151	676,781	1,735,542	447,272	4,031,739
Percent	29.1%	16.8%	43.0%	11.1%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011. 2011 poverty estimates are imputed from 2010 poverty estimates.

Differences by Age Group

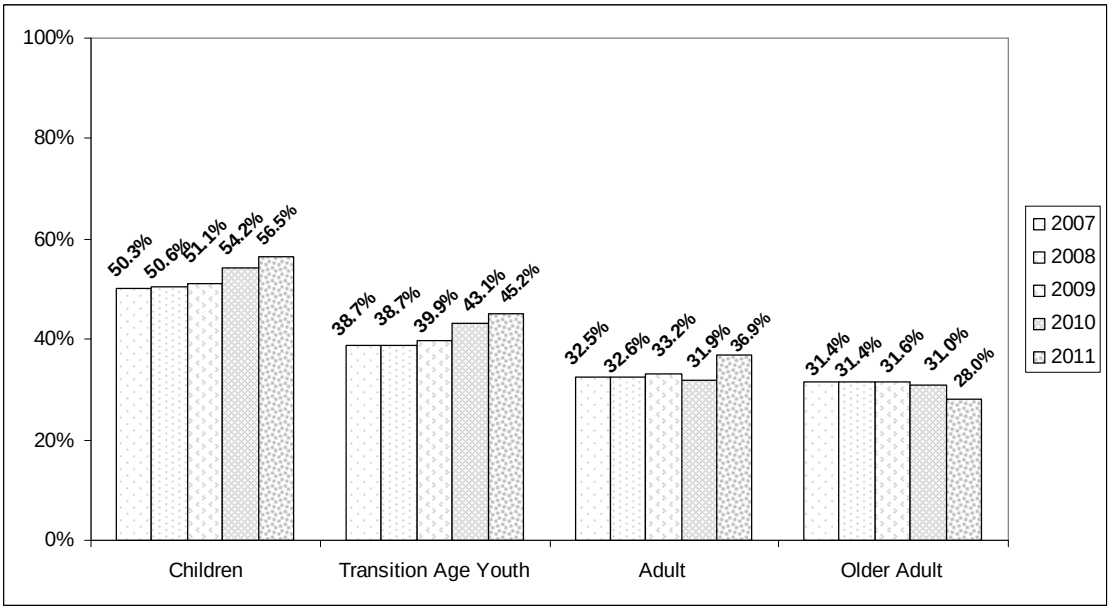
SA 1 at 35.6% has the highest percentage of Children living at or below 200% FPL as compared with the lowest percentage in SA 5 at 14.3%.

SA 5 at 20.1% has the highest percentage of TAY living at or below 200% FPL as compared with the lowest percentage in SA 4 at 15.6%.

SA 5 at 52.8% has the highest percentage of Adults living at or below 200% FPL as compared with the lowest percentage in SA 1 at 37.2%.

SA 3 at 13.1% has the highest percentage of Older Adults living at or below 200% FPL as compared with the lowest percentage in SA 6 at 8.2%.

FIGURE 6: ESTIMATED POVERTY RATE CHANGE AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP CY 2007 - 2011



Note: Estimated Poverty Rate by Age Group = Total population living at or below 200% FPL divided by total population in each age group.

As the percentage of the total population, Children living at or below 200% FPL increased by 6.2% from 50.3% in 2007 to 56.5% in 2011. In 2008 the Child population living at or below 200% FPL was at 50.6, in 2009 it was at 51.1%, and in 2010 it was at 54.2%.

As the percentage of the total population, TAY living at or below 200% FPL increased by 6.5% from 38.7% in 2007 to 45.2% in 2011. In 2008 the TAY population living at or below 200% FPL was at 38.7%, in 2009 it was at 39.9%, and in 2010 it was at 43.1%.

As the percentage of the total population, Adults living at or below the 200% FPL increased by 4.4% from 32.5% in 2007 to 36.9% in 2011. In 2008 the Adult population living at or below 200% FPL was at 32.6%, in 2009 it was at 33.2%, and in 2010 it was at 31.9%.

As the percentage of the total population, Older Adults living at or below the 200% FPL decreased by 3.4% from 31.4% in 2007 to 28.0% in 2011. In 2008

the Older Adult population living at or below 200% FPL was at 31.4%, in 2009 it was at 31.6%, and in 2010 it was at 31.0%.

TABLE 9: ESTIMATED POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2011

Service Area (SA)	Male	Female	SA Total
SA 1	73,786	86,523	160,309
Percent	46.0%	54.0%	4.0%
SA 2	360,231	407,251	767,482
Percent	46.9%	53.1%	**19.0%**
SA 3	286,799	333,880	620,679
Percent	46.2%	53.8%	15.4%
SA 4	274,675	300,132	574,807
Percent	**47.8%**	**52.2%**	14.3%
SA 5	70,160	83,236	153,396
Percent	45.7%	54.3%	**3.8%**
SA 6	288,987	344,346	633,333
Percent	**45.6%**	**54.4%**	15.7%
SA 7	244,311	291,051	535,362
Percent	**45.6%**	**54.4%**	13.3%
SA 8	270,016	316,374	586,390
Percent	46.0%	54.0%	14.5%
Total	1,868,969	2,162,797	4,031,758
Percent	46.4%	53.6%	100.0%

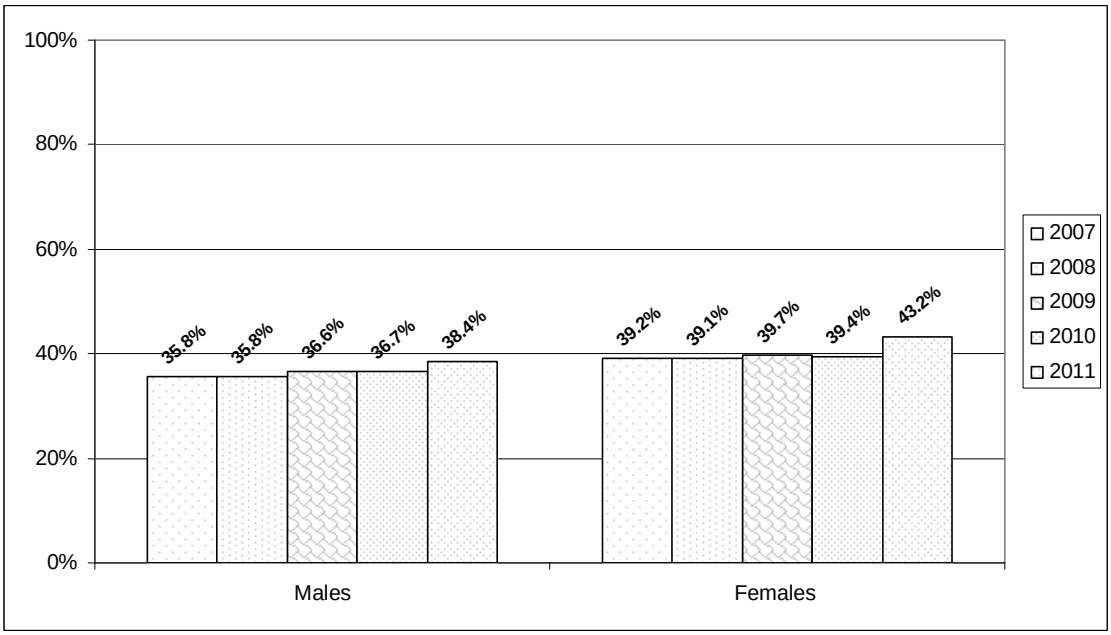
Note: Bold represents the highest and lowest percent in each group.
Data Source: US Census Bureau, 2011. 2011 poverty estimates are imputed from 2010 poverty estimates.

Differences by Gender

SA 4 at 47.8% has the highest percentage of Males living at or below 200% FPL as compared with the lowest percentage in SAs 6 and 7 at 45.6%.

SAs 6 and 7 at 54.4% have the highest percentage of Females living at or below 200% FPL as compared with the lowest percentage in SA 4 at 52.2%.

FIGURE 7: ESTIMATED POVERTY RATE CHANGE AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY GENDER CY 2007 - 2011



Note: Estimated Poverty Rate by Gender = Total population living at or below 200% FPL divided by total population by gender.

As the percentage of the total population, Males living at or below 200% FPL increased by 1.6% from 36.8% in 2007 to 38.4% in 2011. In 2008 the Male population living at or below 200% FPL was at 35.8%, in 2009 it was at 36.6%, and in 2010 it was at 36.7%.

As the percentage of the total population, Females living at or below 200% FPL increased by 4.0% from 39.2% in 2007 to 43.2% in 2011. In 2008 the Female population living at or below 200% FPL was at 39.1%, in 2009 it was at 39.7%, and in 2010 it was at 39.4%.

TABLE 10: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY ETHNICITY AND SERVICE AREA CY 2011

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White
SA 1	3,392	291	8,867	48	2,953
Percent	21.8%	1.9%	57.0%	**0.30%**	19.0%
SA 2	2,647	4,934	44,890	77	21,898
Percent	3.6%	6.6%	60.3%	**0.10%**	29.4%
SA 3	2,277	15,581	35,115	62	7,171
Percent	3.8%	**25.9%**	58.3%	**0.10%**	11.9%
SA 4	2,595	7,708	37,035	90	8,328
Percent	4.7%	13.8%	66.4%	0.20%	14.9%
SA 5	960	2,401	4,164	9	7,346
Percent	6.4%	16.1%	**28.0%**	**0.10%**	**49.4%**
SA 6	14,105	1,045	45,145	88	1,050
Percent	**23.0%**	**1.7%**	73.5%	**0.10%**	**1.7%**
SA 7	1,376	2,567	44,037	68	3,883
Percent	**2.6%**	4.9%	**84.8%**	**0.10%**	7.5%
SA 8	8,343	6,791	34,142	96	7,507
Percent	14.7%	11.9%	60.0%	0.20%	13.2%
Total	35,695	41,318	253,395	538	60,136
Percent	9.1%	10.6%	64.8%	0.10%	15.4%

Note: Bold represents the highest and lowest percent in each group.
[1] SED = Serious Emotional Disturbance (Children), SMI = Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by the California Health Interview Survey (CHIS) for population living at or below 200% FPL at 9.7%.

Differences by Ethnicity

SA 6 at 23.0% has the highest percentage of African Americans living at or below 200% FPL and estimated with SED and SMI as compared with the lowest in SA 7 at 2.6%.

SA 3 at 25.9% has the highest percentage of Asian/Pacific Islanders (API) living at or below 200% FPL and estimated with SED and SMI as compared with the lowest in SA 6 at 1.7%.

SA 7 at 84.8% has the highest percentage of Latinos living at or below 200% FPL and estimated with SED and SMI as compared to the lowest in SA 5 at 28.0%.

SA 1 at 0.3% has the highest percentage of Native Americans living at or below 200% FPL and estimated with SED and SMI as compared to the lowest in SAs 2, 3, 5, 6, and 7 at 0.1%.

SA 5 at 49.4% has the highest percentage of Whites living at or below 200% FPL and estimated with SED and SMI as compared to the lowest in SA 6 at 1.7%.

TABLE 11: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA CY 2011

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60 + yrs
SA 1	5,538	2,930	5,773	1,309
Percent	**35.6%**	18.8%	**37.1%**	8.4%
SA 2	20,133	12,002	33,502	8,809
Percent	27.0%	16.1%	45.0%	11.8%
SA 3	16,561	9,792	25,942	7,911
Percent	27.5%	16.3%	43.1%	**13.1%**
SA 4	13,326	8,710	26,731	6,990
Percent	23.9%	**15.6%**	47.9%	12.5%
SA 5	2,139	2,988	7,851	1,902
Percent	**14.4%**	**20.1%**	**52.8%**	12.8%
SA 6	21,387	11,240	23,765	5,041
Percent	34.8%	18.3%	38.7%	**8.2%**
SA 7	17,623	8,470	20,068	5,769
Percent	33.9%	16.3%	38.6%	11.1%
SA 8	16,993	9,515	24,716	5,656
Percent	29.9%	16.7%	43.5%	9.9%
Total	113,700	65,647	168,348	43,387
Percent	29.1%	16.8%	43.0%	11.1%

Note: Bold represents the highest and lowest percent in each group.
[1] SED = Serious Emotional Disturbance (Children), SMI = Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by the California Health Interview Survey (CHIS) for population living at or below 200% FPL at 9.7%.

Differences by Age Group

SA 1 at 35.6% has the highest percentage of Children living at or below 200% FPL and estimated with SED as compared to the lowest in SA 5 at 14.4%.

SA 5 at 20.1% has the highest percentage of TAY living at or below 200% FPL and estimated with SED and SMI as compared to the lowest in SA 4 at 15.6%.

SA 5 at 52.8% has the highest percentage of Adults living at or below 200% FPL and estimated with SMI as compared to the lowest in SA 1 at 37.1%.

SA 3 at 13.1% has the highest percentage of Older Adults living at or below 200% FPL and estimated with SMI as compared to the lowest in SA 6 at 8.2%.

TABLE 12: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2011

Service Area (SA)	Male	Female
SA 1	7,157	8,393
Percent	46.0%	54.0%
SA 2	34,942	39,503
Percent	46.9%	53.1%
SA 3	27,820	32,386
Percent	46.2%	53.8%
SA 4	26,643	29,113
Percent	**47.8%**	**52.2%**
SA 5	6,806	8,074
Percent	45.7%	54.3%
SA 6	28,032	33,402
Percent	**45.6%**	**54.4%**
SA 7	23,698	28,232
Percent	**45.6%**	**54.4%**
SA 8	26,192	30,688
Percent	46.0%	54.0%
TOTAL	181,291	209,791
Percent	46.4%	53.6%

Note: Bold represents the highest and lowest percent in each group. [1]SED = Serious Emotional Disturbance (Children), SMI = Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by the California Health Interview Survey (CHIS) for population living at or below 200% FPL at 9.7%.

Differences by Gender

SA 4 at 47.8% has the highest percentage of Males living at or below 200% FPL and estimated with SED and SMI as compared with the lowest in SAs 6 and 7 at 45.6%.

SAs 6 and 7 at 54.4% have the highest percentage of Females living at or below 200% FPL and estimated with SED and SMI as compared with the lowest in SA 4 at 52.2%.

Population Enrolled in Medi-Cal

TABLE 13: POPULATION ENROLLED IN MEDI-CAL BY ETHNICITY AND SERVICE AREA MARCH 2011

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	SA Total
SA 1	23,827	1,928	47,957	234	17,920	91,866
Percent	25.9%	2.1%	52.2%	**0.25%**	19.5%	4.7%
SA 2	13,868	23,474	204,861	384	110,407	352,994
Percent	3.9%	6.6%	58.1%	0.11%	31.3%	**18.1%**
SA 3	14,162	79,467	194,328	387	29,259	317,603
Percent	4.5%	**25.0%**	61.2%	0.12%	9.2%	16.3%
SA 4	13,202	33,271	167,247	258	26,840	240,818
Percent	5.5%	13.8%	69.4%	0.11%	11.2%	12.4%
SA 5	5,449	2,984	15,555	86	15,935	40,009
Percent	13.6%	7.5%	**38.9%**	0.21%	**39.8%**	**2.1%**
SA 6	99,854	3,070	242,153	209	6,090	351,376
Percent	**28.4%**	**0.9%**	68.9%	**0.06%**	**1.7%**	**18.1%**
SA 7	8,229	13,203	241,533	355	17,365	280,685
Percent	**2.9%**	4.7%	**86.1%**	0.13%	6.2%	14.4%
SA 8	57,654	31,372	155,935	427	24,303	269,691
Percent	21.4%	11.6%	57.8%	0.16%	9.0%	13.9%
Total	236,245	188,769	1,269,569	2,340	248,119	1,945,042
Percent	12.1%	9.7%	65.3%	0.12%	12.8%	100.0%

Note: Bold represents the highest and lowest percent in each group.
Data Source: State MEDS File, March 2011.

Differences by Ethnicity

SA 6 at 28.4% has the highest percentage of African Americans enrolled in Medi-Cal as compared with the lowest in SA 7 at 2.9%.

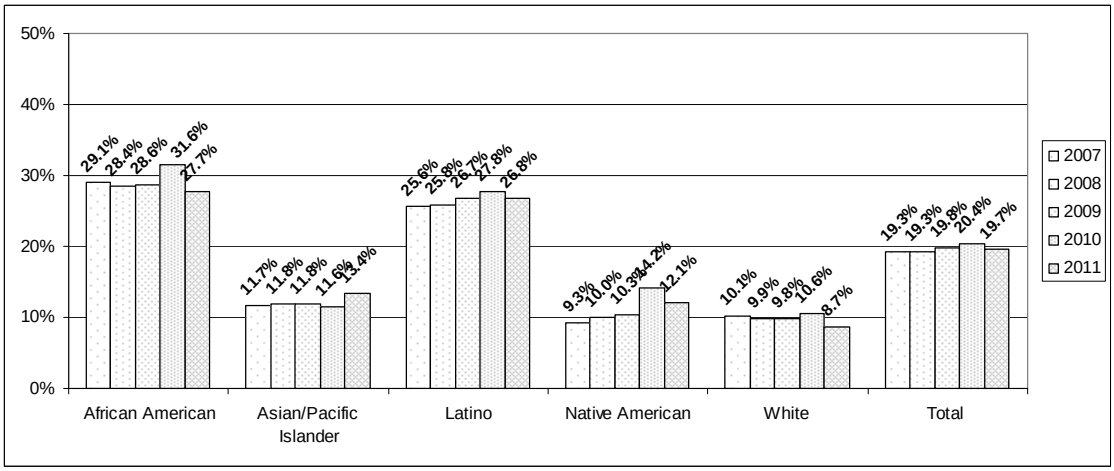
SA 3 at 25.0% has the highest percentage of Asian/Pacific Islanders (API) enrolled in Medi-Cal as compared with the lowest in SA 6 at 0.9%.

SA 7 at 86.1% has the highest percentage of Latinos enrolled in Medi-Cal as compared with the lowest in SA 5 at 38.9%.

SA 1 at 0.25% has the highest percentage of Native Americans enrolled in Medi-Cal as compared with the lowest in SA 6 at 0.06%.

SA 5 at 39.8% has the highest percentage of Whites enrolled in Medi-Cal as compared with the lowest in SA 6 at 1.7%.

FIGURE 8: MEDI-CAL ENROLLMENT RATE[1] CHANGE BY ETHNICITY MARCH 2007 - 2011



[1] Medi-Cal Enrollment Rate = Medi-Cal enrolled population divided by total population in each ethnic group.

As the percentage of the total population, the African American Medi-Cal enrollment rate has decreased by 1.4% from a rate of 29.1% in March 2007 to 27.7% in March 2011. In March 2008 the African American Medi-Cal enrollment rate was at 28.4%, in March 2009 it was at 28.6%, and in March 2010 it was at 31.6%.

As the percentage of the total population, the Asian/Pacific Islander (API) Medi-Cal enrollment rate increased by 1.7% from a rate of 11.7% in March 2007 to 13.4% in March 2011. In March 2008 the API Medi-Cal enrollment rate was at 11.8%, in March 2009 it was at 11.8%, and in March 2010 it was at 11.6%.

As the percentage of the total population, the Latino Medi-Cal enrollment rate increased 1.2% from 25.6% in March of 2007 to 26.8% in March 2011. In March 2008 the Latino Medi-Cal enrollment rate was at 25.8%, in March 2009 it was at 26.7%, and in March 2010 it was at 27.8%.

As the percentage of the total population, the Native American Medi-Cal enrollment rate increased 2.8% from 9.3% in March 2007 to 12.1% in March 2011. In March 2008 the Native American Medi-Cal enrollment rate was at 10.0%, in March 2009 it was at 10.3%, and in March 2010 it was at 14.2%.

As the percentage of the total population, the White Medi-Cal enrollment rate decreased 1.4% from 10.1% in March 2007 to 8.7% in March 2011. In 2008 the White Medi-Cal enrollment rate was at 9.9%, in March 2009 it was at 9.8%, and in March 2010 it was at 10.6%.

TABLE 14: POPULATION ENROLLED IN MEDI-CAL BY AGE GROUP AND SERVICE AREA MARCH 2011

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60 + yrs	SA Total
SA 1	47,800	15,887	20,688	7,491	91,866
Percent	52.0%	**17.3%**	**22.5%**	**8.2%**	4.7%
SA 2	165,782	47,615	69,625	69,972	352,994
Percent	47.0%	13.5%	19.7%	19.8%	**18.1%**
SA 3	154,690	47,193	57,447	58,273	317,603
Percent	48.7%	14.9%	18.1%	18.3%	16.3%
SA 4	113,691	32,836	43,887	50,404	240,818
Percent	47.2%	13.6%	18.2%	21.0%	12.4%
SA 5	15,383	4,708	8,298	11,620	40,009
Percent	**38.4%**	**12.0%**	20.6%	**29.0%**	**2.1%**
SA 6	198,304	57,069	64,415	31,588	351,376
Percent	**56.4%**	16.2%	18.3%	9.1%	**18.1%**
SA 7	153,753	44,208	46,939	35,785	280,685
Percent	54.8%	15.8%	**16.7%**	12.7%	14.4%
SA 8	140,147	42,459	53,259	33,826	269,691
Percent	52.0%	16.0%	19.6%	12.4%	13.9%
Total	989,550	291,975	364,558	298,959	1,945,042
Percent	50.9%	15.0%	18.7%	15.4%	100.0%

Notes:
1. Bold represents the highest and lowest percent in each group.
2. Data excludes Medi-Cal enrolled who are without Service Area designations (N = 90,660 or 4.05% from the total count of 2,239,690 in the States Meds Beneficiary file.)
3. Data Source: State MEDS File, March 2011.

Differences by Age Group

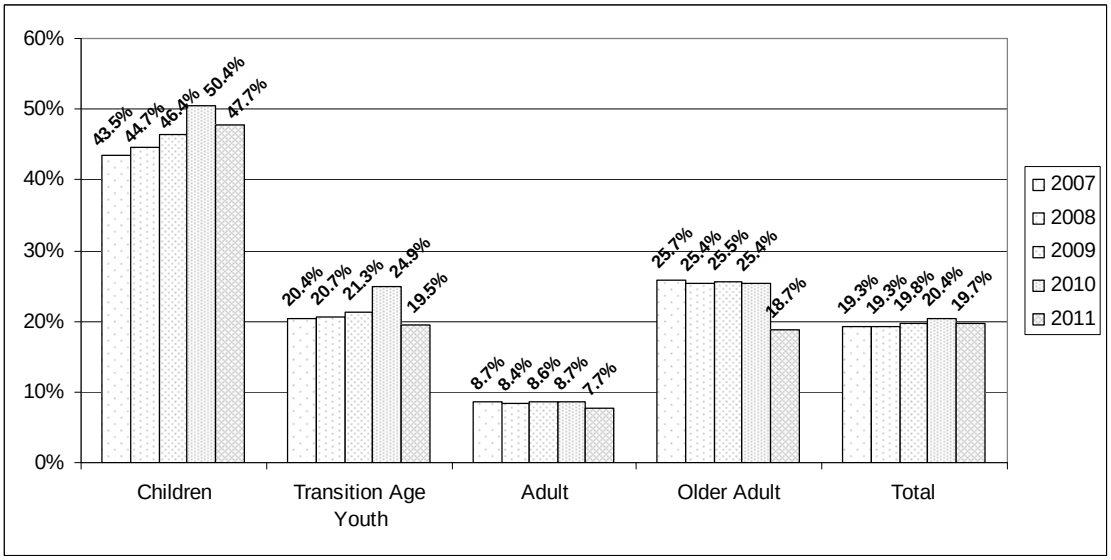
SA 6 at 56.4% has the highest percentage of Children enrolled in Medi-Cal as compared with the lowest in SA 5 at 38.4%.

SA 1 at 17.3% has the highest percentage of TAY enrolled in Medi-Cal as compared with the lowest in SA 5 at 12.0%.

SA 1 at 22.5% has the highest percentage of Adults enrolled in Medi-Cal as compared with the lowest in SA 7 at 16.7%.

SA 5 at 29.0% has the highest percentage of Older Adults enrolled in Medi-Cal as compared with the lowest in SA 1 at 8.2%.

FIGURE 9: MEDI-CAL ENROLLMENT RATE[1] CHANGE BY AGE GROUP MARCH 2007 - 2011



[1] Medi-Cal Enrollment Rate = Medi-Cal enrolled population divided by total population in each age group.

As the percentage of the total population, the Child Medi-Cal enrollment rate increased 4.2% from 43.5% in March 2007 to 47.7% in March 2011. In March 2008 the Child Medi-Cal enrollment rate was at 44.7, in March 2009 it was at 46.4%, and in March 2010 it was at 50.4%.

As the percentage of the total population, the TAY Medi-Cal enrollment rate decreased 0.9% from 20.4% in March 2007 to 19.5% in March 2011. In March 2008 the TAY Medi-Cal enrollment rate was at 20.7%, in March 2009 it was at 21.3%, and in March 2010 it was at 24.9%.

As the percentage of the total population, the Adult Medi-Cal enrollment decreased 1.0% from 8.7% in March 2007 to 7.7% in March 2011. In March 2008 the Adult Medi-Cal enrollment rate was at 8.4%, in March 2009 it was at 8.6%, and in March 2010 it was at 8.7%.

As the percentage of the total population, the Older Adult Medi-Cal enrollment rate decreased 7.0% from 25.7% in March 2007 to 18.7% in March 2011. In March 2008 the Older Adult Medi-Cal enrollment rate was at 25.4%, in March 2009 it was at 25.5%, and in March 2010 it was at 25.4%.

As the percentage of the total population, the Total Medi-Cal enrollment increased 0.4% from 19.3% in March 2007 to 19.7% in March 2011. In March 2008 the Total Medi-Cal enrollment rate was at 19.3%, in March 2009 it was at 19.8%, and in March 2010 it was at 20.4%.

TABLE 15: POPULATION ENROLLED IN MEDI-CAL BY GENDER AND SERVICE AREA
MARCH 2011

Service Area (SA)	Male	Female	SA Total
SA 1	51,295	40,571	91,866
Percent	55.8%	44.2%	4.7%
SA 2	193,996	158,998	352,994
Percent	55.0%	45.0%	**18.1%**
SA 3	175,181	142,422	317,603
Percent	55.2%	44.8%	16.3%
SA 4	132,463	108,355	240,818
Percent	55.0%	45.0%	12.4%
SA 5	22,381	17,628	40,009
Percent	**55.9%**	**44.1%**	**2.1%**
SA 6	194,007	157,369	351,376
Percent	55.2%	44.8%	**18.1%**
SA 7	153,904	126,781	280,685
Percent	**54.8%**	**45.2%**	14.4%
SA 8	149,854	119,837	269,691
Percent	55.6%	44.4%	13.9%
Total	1,073,081	871,961	1,945,042
Percent	55.2%	44.8%	100.0%

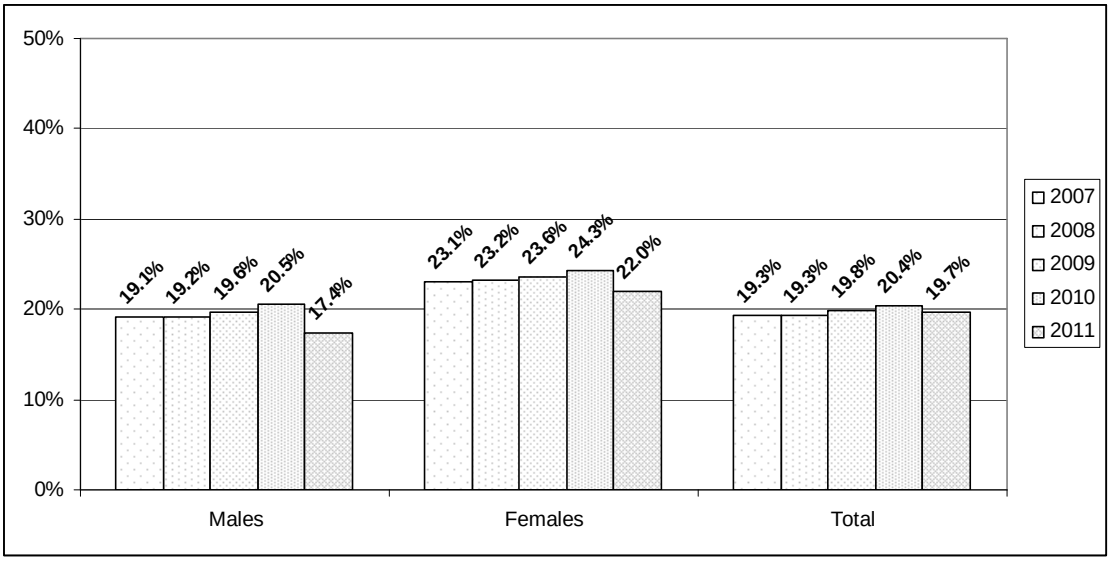
Notes:
1. Bold represents the highest and lowest percent in each group.
2. Data excludes Medi-Cal enrolled who are without Service Area designations (N = 90,660 or 4.05% from the total count of 2,239,690 in the States Meds Beneficiary file.)
3. Data Source: State MEDS File, March 2011.

Differences by Gender

SA 5 at 55.9% has the highest percentage of Males enrolled in Medi-Cal as compared with the lowest in SA 7 at 54.8%.

SA 7 at 45.2% has the highest percentage of Females enrolled in Medi-Cal as compared with the lowest in SA 5 at 44.1%.

FIGURE 10: MEDI-CAL ENROLLMENT RATE[1] CHANGE BY GENDER MARCH 2007 - 2011



[1] Medi-Cal Enrollment Rate = Medi-Cal enrolled population divided by total population in each group.

As the percentage of the total population, the Male Medi-Cal enrollment rate decreased 1.7% from 19.1% in March 2007 to 17.4% in March 2011. In March 2008 the Male Medi-Cal enrollment rate was at 19.2%, in March 2009 it was at 19.6%, and in March 2010 it was at 20.5%.

As the percentage of the total population, the Female Medi-Cal enrollment rate decreased 1.1% from 23.1% in March of 2008 to 22.0% in March 2011. In March 2008 the female Medi-Cal enrollment rate was at 23.2%, in 2009 it was at 23.6%, and in March 2010 it was at 24.3%.

As the percentage of the total population, the Total Medi-Cal enrollment increased 0.4% from 19.3% in March 2007 to 19.7% in March 2011. In March 2008 the Total Medi-Cal enrollment rate was at 19.3%, in March 2009 it was at 19.8%, and in March 2010 it was at 20.4%.

TABLE 16: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG MEDI-CAL ENROLLED POPULATION BY ETHNICITY AND SERVICE AREA MARCH 2011

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Service Area Total
SA 1	2,311	187	4,652	23	1,738	8,911
Percent	25.9%	2.1%	52.2%	**0.30%**	19.5%	4.7%
SA 2	1,345	2,277	19,872	37	10,709	34,240
Percent	3.9%	6.6%	58.0%	**0.10%**	31.3%	**18.1%**
SA 3	1,374	7,708	18,850	38	2,838	30,807
Percent	4.5%	**25.0%**	61.2%	**0.10%**	9.2%	16.3%
SA 4	1,281	3,227	16,223	25	2,603	23,359
Percent	5.5%	13.8%	69.4%	**0.10%**	11.1%	12.4%
SA 5	529	289	1,509	8	1,546	3,881
Percent	13.6%	7.5%	**38.9%**	0.20%	**39.8%**	**2.1%**
SA6	9,686	298	23,489	20	591	34,083
Percent	**28.4%**	**0.9%**	68.9%	**0.10%**	**1.7%**	**18.1%**
SA 7	798	1,281	23,429	34	1,684	27,226
Percent	**2.9%**	4.7%	**86.1%**	**0.10%**	6.2%	14.4%
SA8	5,592	3,043	15,126	41	2,357	26,160
Percent	21.4%	11.6%	57.8%	0.20%	9.0%	13.9%
Total	22,916	18,311	123,148	227	24,068	188,669
Percent	12.1%	9.7%	65.3%	0.10%	12.8%	100.0%

Note: Bold represents the highest and lowest percent in each group.
[1] SED = Serious Emotional Disturbance (Children), SMI = Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by the California Health Interview Survey (CHIS) for population living at or below 200% FPL at 9.7%.

Differences by Ethnicity

SA 6 at 28.4% has the highest percentage of African Americans estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 7 at 2.9%.

SA 3 at 25.0% has the highest percentage of Asian/Pacific Islanders (API) estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 6 at 0.9%.

SA 7 at 86.1% has the highest percentage of Latinos estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 5 at 38.9%.

SA 1 at 0.3% has the highest percentage of Native Americans estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SAs 2, 3, 4, 6 and 7 at 0.1%.

SA 5 at 39.8% has the highest percentage of Whites estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 6 at 1.7%.

TABLE 17: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG MEDI-CAL ENROLLED POPULATION BY AGE GROUP AND SERVICE AREA MARCH 2011

Service Area (SA)	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60 + yrs	SA Total
SA 1	4,637	1,541	2,007	727	8,911
Percent	52.0%	**17.3%**	**22.5%**	**8.2%**	**4.7%**
SA 2	16,081	4,619	6,754	6,787	34,240
Percent	47.0%	13.5%	19.7%	19.8%	18.1%
SA 3	15,005	4,578	5,572	5,652	30,807
Percent	48.7%	14.9%	18.1%	18.3%	16.3%
SA 4	11,028	3,185	4,257	4,889	23,359
Percent	47.2%	13.6%	18.2%	20.9%	12.4%
SA 5	1,492	457	805	1,127	3,881
Percent	**38.4%**	**11.8%**	20.7%	**29.0%**	2.1%
SA 6	19,235	5,536	6,248	3,064	34,083
Percent	**56.4%**	16.2%	18.3%	9.0%	**18.1%**
SA 7	14,914	4,288	4,553	3,471	27,226
Percent	54.8%	15.8%	**16.7%**	12.7%	14.4%
SA 8	13,594	4,119	5,166	3,281	26,160
Percent	52.0%	15.7%	19.7%	12.5%	13.9%
Total	95,986	28,322	35,362	28,999	188,669
Percent	50.9%	15.0%	18.7%	15.4%	100.0%

Note: Bold represents the highest and lowest percent in each group.
[1] SED = Serious Emotional Disturbance (Children), SMI = Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by the California Health Interview Survey (CHIS) for population living at or below 200% FPL at 9.7%.

Differences by Age Group

SA 6 at 56.4% has the highest percentage of Children estimated with SED enrolled in Medi-Cal as compared with the lowest in SA 5 at 38.4%.

SA 1 at 17.3% has the highest percentage of TAY estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 5 at 11.8%.

SA 1 at 22.5% has the highest percentage of Adults estimated with SMI enrolled in Medi-Cal as compared with the lowest in SA 7 at 16.7%.

SA 5 at 29.0% has the highest percentage of Older Adults estimated with SMI enrolled in Medi-Cal as compared with the lowest in SA 1 at 8.2%.

TABLE 18: ESTIMATED PREVALENCE OF SED & SMI[1] AMONG MEDI-CAL ENROLLED POPULATION BY GENDER AND SERVICE AREA MARCH 2011

Service Area (SA)	Female	Male	SA Total
SA 1	4,976	3,935	8,911
Percent	55.8%	44.2%	4.7%
SA 2	18,818	15,423	34,240
Percent	54.9%	45.1%	**18.2%**
SA 3	16,993	13,815	30,807
Percent	55.2%	44.8%	16.3%
SA 4	12,849	10,510	23,359
Percent	55.0%	45.0%	12.4%
SA 5	2,171	1,710	3,881
Percent	**55.9%**	**44.1%**	**2.1%**
SA 6	18,819	15,265	34,083
Percent	55.2%	44.8%	18.1%
SA 7	14,929	12,298	27,226
Percent	**54.8%**	**45.2%**	14.4%
SA 8	14,536	11,624	26,160
Percent	55.6%	44.4%	13.9%
Total	104,089	84,580	188,669
Percent	55.2%	44.8%	100.0%

Note: Bold represents the highest and lowest percent in each group.
[1] SED = Serious Emotional Disturbance (children), SMI = Serious Mental Illness (Adults). Estimated prevalence rate of mental illness is provided by the California Health Interview Survey (CHIS) for population living at or below 200% FPL at 9.7%.

Differences by Gender

SA 5 at 55.9% has the highest percentage of Males estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 7 at 54.8%.

SA 7 at 45.2% has the highest percentage of Females estimated with SED and SMI enrolled in Medi-Cal as compared with the lowest in SA 5 at 44.1%.

TABLE 19: POPULATION ENROLLED IN MEDI-CAL BY THRESHOLD LANGUAGE AND SERVICE AREA
MARCH 2011

Service Area (SA)	Armen-ian	Cambod-ian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	81	11	14	66,573	27	65	5	19	5	24,756	145	72	91,866
Percent	0.1%	0.0%	0.0%	**72.5%**	0.0%	0.1%	0.0%	0.0%	0.0%	**26.9%**	0.2%	0.1%	100.0%
SA 2	48,838	165	160	144,193	6,301	2,999	262	210	3,847	138,960	2,890	2,259	352,994
Percent	**13.8%**	0.0%	0.0%	**40.8%**	**1.8%**	0.8%	0.1%	0.1%	**1.1%**	**39.4%**	0.8%	0.6%	100.0%
SA 3	2,022	1,006	19,796	149,690	215	1,694	14,834	6,349	96	103,655	1,913	15,766	317,603
Percent	0.6%	0.3%	**6.2%**	**47.1%**	0.1%	0.5%	**4.7%**	**2.0%**	0.0%	**32.6%**	0.6%	**5.0%**	100.0%
SA 4	7,235	527	6,003	83,900	464	10,683	836	826	4,807	121,034	2,990	1,395	240,818
Percent	**3.0%**	0.2%	**2.5%**	**34.8%**	0.2%	**4.4%**	0.3%	0.3%	**2.0%**	**50.3%**	1.2%	0.6%	100.0%
SA 5	47	7	43	24,130	3,382	256	121	90	1,313	10,318	55	54	40,009
Percent	0.1%	0.0%	0.1%	**60.3%**	**8.5%**	0.6%	0.3%	0.2%	3.3%	**25.8%**	0.1%	0.1%	100.0%
SA 6	22	125	56	173,817	6	833	22	17	22	176,287	82	65	351,376
Percent	0.0%	0.0%	0.0%	**49.5%**	0.0%	0.2%	0.0%	0.0%	0.0%	**50.2%**	0.0%	0.0%	100.0%
SA 7	650	727	482	131,376	28	1,827	866	382	56	142,450	945	610	280,685
Percent	0.2%	0.3%	0.2%	**46.8%**	0.0%	0.7%	0.3%	0.1%	0.0%	**50.8%**	0.3%	0.2%	100.0%
SA 8	91	5,290	191	156,611	286	2,160	376	275	135	100,045	1,680	2,393	269,691
Percent	0.0%	**2.0%**	0.1%	**58.1%**	0.1%	0.8%	0.1%	0.1%	0.1%	**37.1%**	0.6%	0.9%	100.0%
Total	58,986	7,858	26,745	930,290	10,709	20,517	17,322	8,168	10,281	817,505	10,700	22,614	1,941,695
Percent	3.0%	0.4%	1.4%	47.8%	0.6%	1.1%	0.9%	0.4%	0.5%	42.0%	0.6%	1.2%	100.0%

Note: SA Threshold Languages are in bold. Arabic is a Countywide threshold language and is not included, N = 3,347 (0.2%). 4,149 (0.2%) individuals enrolled in Medi-Cal reported "Other" as a primary language. 78,084 (3.5%) were "Unknown/Missing" for primary language and 90,660 (4.1%) were missing a Service Area designation.
Data Source: State MEDS File, March 2011.

Table 19 shows that among the thirteen (13) threshold languages, Spanish is the only Non-English threshold language present in all of the Service Areas. The Service Area with the highest percentage of Medi-Cal Enrolled with English as the primary language is SA 1 at 72.5%, and the lowest percentage is SA 4 at 34.8%. The Service Area with the highest percentage of Medi-Cal Enrolled with Spanish as the primary language is SA 7 at 50.8%, and the lowest percentage is SA 5 at 25.8%.

SA 1 has two (2) threshold languages: English (72.5%) and Spanish (26.9%).

SA 2 has five (5) threshold languages: Armenian (13.8%), English (40.8%), Farsi (1.8%), Russian (1.1%), and Spanish (39.4%).

SA 3 has six (6) threshold languages: Cantonese (6.2%), English (47.1%), Mandarin (4.7%), Other Chinese (2.0%), Spanish (32.6%), and Vietnamese (5.0%).

SA 4 has six (6) threshold languages: Armenian (3.0%), Cantonese (2.5%), English (34.8%), Korean (4.4%), Russian (2.0%), and Spanish (50.3%).

SA 5 has three (3) threshold languages: English (60.3%), Farsi (8.5%), and Spanish (25.8%).

SA 6 has two (2) threshold languages: English (49.5%) and Spanish (50.2%).

SA 7 has two (2) threshold languages: English (46.8%) and Spanish (50.8%).

SA 8 has three (3) threshold languages: Cambodian (2.0%), English (58.1%), and Spanish (37.1%).

Countywide, the highest percentage of Medi-Cal Enrolled with English as the primary language is 47.8% and the second highest is Spanish at 42.0%. All other threshold languages range between 3.0% (Farsi) to 0.4% (Cambodian and Other Chinese).

Consumers Served In Outpatient Short Doyle/Medi-Cal Facilities

TABLE 20: CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND SERVICE AREA FY 2011 - 2012

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	Other	White	SA Total
SA 1	3,502	103	3,162	65	51	2,902	9,785
Percent	35.8%	1.0%	32.3%	0.70%	0.5%	29.7%	5.3%
SA 2	3,059	1,042	14,705	117	367	9,730	29,020
Percent	10.5%	3.6%	50.7%	0.40%	1.3%	33.5%	15.6%
SA 3	3,405	2,124	16,180	114	138	4,469	26,430
Percent	12.9%	**8.0%**	61.3%	0.40%	0.5%	16.9%	14.2%
SA 4	10,678	2,648	21,867	285	203	7,481	43,162
Percent	24.7%	6.1%	50.7%	0.70%	0.5%	17.3%	23.3%
SA 5	2,228	247	2,678	46	136	3,799	9,134
Percent	24.4%	2.7%	**29.3%**	0.50%	**1.5%**	**41.6%**	4.9%
SA 6	16,228	238	13,519	51	44	1,161	31,241
Percent	**51.9%**	**0.8%**	43.3%	**0.20%**	**0.1%**	**3.7%**	16.8%
SA 7	1,882	535	16,178	282	82	2,844	21,803
Percent	**8.6%**	2.5%	**74.2%**	**1.30%**	0.4%	13.0%	11.7%
SA8	10,384	2,284	13,886	121	195	6,941	33,811
Percent	30.7%	6.8%	41.0%	0.40%	0.6%	20.5%	18.2%
Total	45,474	8,702	93,251	948	1,141	36,119	185,635
Percent	24.5%	4.7%	50.2%	0.50%	0.6%	19.5%	100.0%

Note: Bold represents the highest and lowest percent in each group. Excludes those whose ethnicity is unknown N = 6,389) SA Total reflects unduplicated count of consumers served. Some consumers (N = 18,676) were served in more than one SA or 204,311 duplicated count. Data Source: LACDMH-IS Database, October 2012.

Differences by Ethnicity

SA 6 at 51.9% has the highest percentage of African American consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 7 at 8.6%.

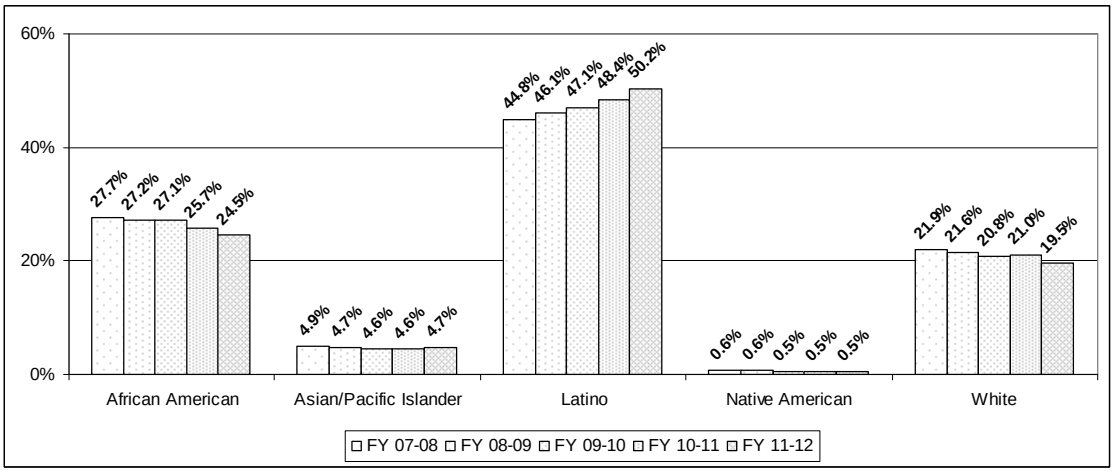
SA 3 at 8.0% has the highest percentage of Asian/Pacific Islander (API) consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 6 at 0.8%.

SA 7 at 74.2% has the highest percentage of Latino consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 5 at 29.3%.

SA 7 at 1.3% has the highest percentage of Native American consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 6 at 0.2%.

SA 5 at 41.6% has the highest percentage of White consumers served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 6 at 3.7%.

FIGURE 11: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY FY 2007 - 2008 TO FY 2011 - 2012



As the percentage of the total population, African Americans served in Short Doyle/Medi-Cal facilities decreased by 3.2% from 27.7% to 24.5% between FY 07-08 and FY 11-12. In FY 08-09 the percentage of African Americans served in Short Doyle/Medi-Cal facilities was at 27.2%, in FY 09-10 it was at 27.1%, and in FY 10-11 it was at 25.7%.

As the percentage of the total population, Asian/Pacific Islanders served in Short Doyle/Medi-Cal facilities decreased by 0.2% from 4.9% to 4.7% between FY 07-08 and FY 11-12. In FY 08-09 the percentage of Asian/Pacific Islanders served in Short Doyle/Medi-Cal facilities was at 4.7%, in FY 09-10 it was at 4.6%, and in FY 10-11 it was at 4.6%.

As the percentage of the total population, Latinos served in Short Doyle/Medi-Cal facilities increased by 5.4% from 44.8% to 50.2% between FY 07-08 and FY 11-12. In FY 08-09 the percentage of Latinos served in Short Doyle/Medi-Cal facilities was at 46.1%, in FY 09-10 it was at 47.1%, and in FY 10-11 it was at 48.4%.

As the percentage of the total population, Native Americans served in Short Doyle/Medi-Cal facilities decreased by 0.1% from 0.6% to 0.5% between FY 07-08 and FY 11-12. In FY 08-09 the percentage of Native Americans served in Short Doyle/Medi-Cal facilities was at 0.6%, in FY 09-10 it was at 0.5%, and in FY 10-11 it was at 0.5%.

As the percentage of the total population, Whites served in Short Doyle/Medi-Cal facilities decreased by 2.4% from 21.9% to 19.5% between FY 07-08 and FY 11-

12. In FY 08-09 the percentage of Whites served in Short Doyle/Medi-Cal facilities was at 21.6%, in FY 09-10 it was at 20.8% in FY 10-11 it was at 21.0%.

TABLE 21: CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP AND SERVICE AREA FY 2011 - 2012

Service Area	Children 0-15 yrs	Transition Age Youth (TAY) 16-25 yrs	Adult 26-59 yrs	Older Adult 60 + yrs	SA Total
SA 1	3,704	1,831	3,859	391	9,785
Percent	37.9%	18.7%	39.4%	**4.0%**	5.3%
SA 2	8,750	5,838	12,148	2,284	29,020
Percent	30.1%	20.1%	41.9%	7.9%	15.6%
SA 3	11,135	5,892	8,001	1,401	26,429
Percent	**42.1%**	**22.3%**	30.3%	5.3%	14.2%
SA 4	13,411	7,195	18,811	3,745	43,162
Percent	31.0%	16.7%	43.6%	8.7%	**23.3%**
SA 5	2,494	1,472	4,290	878	9,134
Percent	**27.3%**	**16.1%**	**47.0%**	**9.6%**	**4.9%**
SA 6	11,784	5,151	12,641	1,665	31,241
Percent	37.7%	16.5%	40.5%	5.3%	16.8%
SA 7	8,937	4,508	7,255	1,103	21,803
Percent	41.0%	20.7%	**33.3%**	5.0%	11.7%
SA 8	11,077	5,752	14,705	2,277	33,811
Percent	32.8%	17.0%	43.5%	6.7%	18.2%
Total	63,141	32,888	76,347	13,259	185,635
Percent	34.1%	17.7%	41.1%	7.1%	100.0%

Note: Bold represents the highest and lowest percent in each group. Total reflects unduplicated count of consumers served. Some consumers (N = 18,676) were served in more than one SA or 204,311 duplicated count. Excludes consumers not reporting their date of birth, N = 318).
Data Source: LACDMH-IS Database, October 2012.

Differences by Age Group

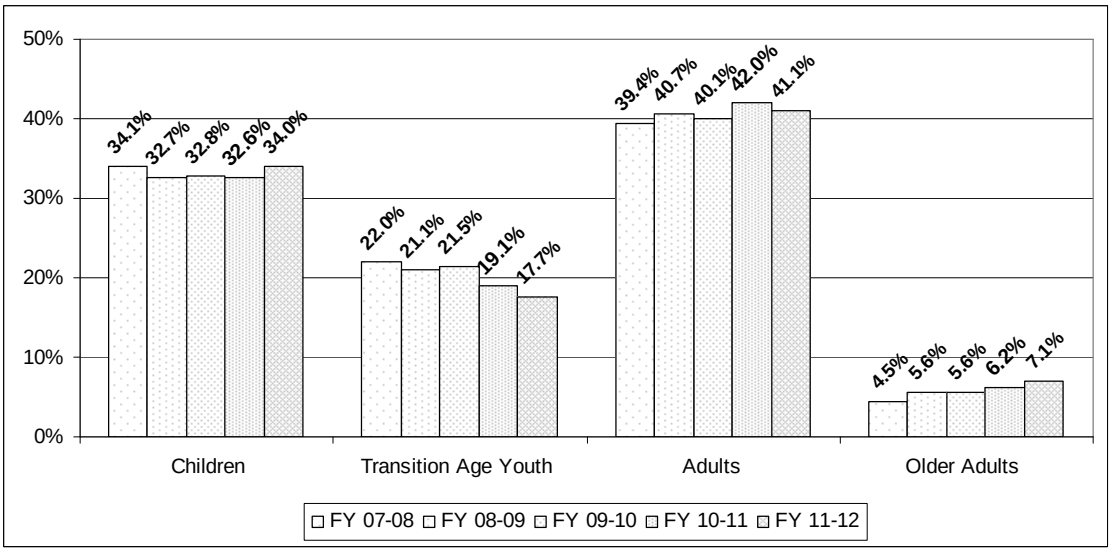
SA 3 at 42.1% has the highest percentage of Children served as compared with the lowest percentage in SA 5 at 27.3%.

SA 3 at 22.3% has the highest percentage of TAY served as compared with the lowest percentage in SA 5 at 16.1%.

SA 5 at 47.0% has the highest percentage of Adults served as compared with the lowest percentage in SA 7 at 33.3%.

SA 5 at 9.6% has the highest percentage of Older Adults served as compared with the lowest percentage in SA 1 at 4.0%.

FIGURE 12: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP FY 2007 - 2008 TO FY 2011 - 2012



As the percentage of the total population, Children served in Short Doyle/Medi-Cal facilities decreased by 0.1% from 34.1% to 34.0% between FY 07-08 and FY 11-12. In FY 08-09 the percentage of Children served in Short Doyle/Medi-Cal facilities was at 32.7%, in FY 09-10 it was at 32.8%, and in FY 10-11 it was at 32.6%.

As the percentage of the total population, TAY served in Short Doyle/Medi-Cal facilities decreased by 4.3% from 22.0% to 17.7% between FY 07-08 and FY 11-12. In FY 08-09 the percentage of TAY served in Short Doyle/Medi-Cal facilities was at 21.1%, in FY 09-10 it was at 21.5%, and in FY 10-11 it was at 19.1%.

As the percentage of the total population, Adults served in Short Doyle/Medi-Cal facilities increased by 1.7% from 39.4% to 41.1% between FY 07-08 and FY 11-12. In FY 08-09 the percentage of Adults served in Short Doyle/Medi-Cal facilities was at 40.7%, in FY 09-10 it was at 40.1%, and in FY 10-11 it was at 42.0%.

As the percentage of the total population, Older Adults served in Short Doyle/Medi-Cal facilities increased by 2.6% from 4.5% to 7.1% between FY 07-08 and FY 11-12. In FY 08-09 the percentage of Older Adults served in Short Doyle/Medi-Cal facilities was at 5.6%, in FY 09-10 it was at 5.6%, and in FY 10-11 it was at 6.2%.

TABLE 22: CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY GENDER AND SERVICE AREA
FY 2011 - 2012

Service Area (SA)	Female	Male	SA Total
SA 1	5,203	4,582	9,785
Percent	**53.2%**	**46.8%**	**3.9%**
SA 2	14,635	14,385	29,020
Percent	50.4%	49.6%	**21.7%**
SA 3	12,858	13,572	26,430
Percent	48.6%	51.4%	17.8%
SA 4	20,081	23,081	43,162
Percent	**46.5%**	**53.5%**	11.4%
SA 5	4,291	4,843	9,134
Percent	47.0%	53.0%	6.5%
SA 6	15,903	15,338	31,241
Percent	50.9%	49.1%	10.2%
SA 7	10,989	10,814	21,803
Percent	50.4%	49.6%	13.2%
SA 8	17,114	16,697	33,811
Percent	50.6%	49.4%	15.5%
Total	92,503	93,132	185,635
Percent	49.8%	50.2%	100.0%

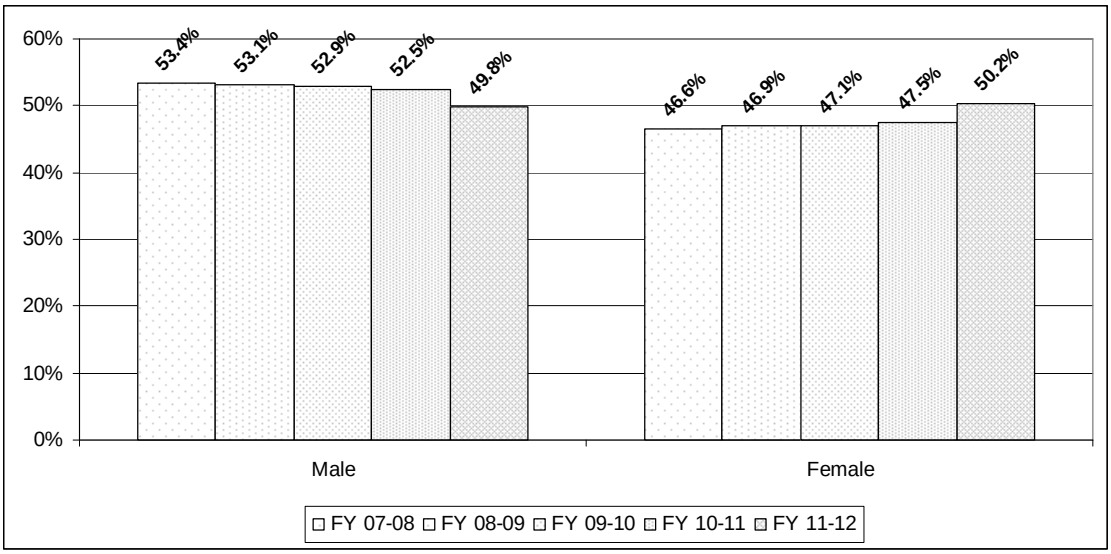
Note: Bold represents the highest and lowest percent in each group. Excludes consumers not reporting their gender, N = 67). SA Total reflects unduplicated count of consumers served. Some consumers (N = 18,676) were served in more than one SA or 204,311 duplicated count. Data Source: LACDMH-IS Database, October 2012.

Differences by Gender

SA 1 at 53.2% has the highest percentage of Males served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 4 at 46.5%.

SA 4 at 53.5% has the highest percentage of Females served in Short Doyle/Medi-Cal facilities as compared with the lowest percentage in SA 1 at 46.8%.

FIGURE 13: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY GENDER FY 2007 - 2008 TO FY 2011 - 2012



As the percentage of the total population, Males served in Short Doyle/Medi-Cal facilities decreased by 3.6% from 53.4% to 49.8% between FY 07-08 and FY 11-12. In FY 08-09 the percent of Males served in Short Doyle/Medi-Cal facilities was at 53.1%, in FY 09-10 it was at 52.9%, and in FY 10-11 it was at 52.5%.

As the percentage of the total population, Females served in Short Doyle/Medi-Cal facilities increased by 3.6% from 46.6% to 50.2% between FY 07-08 and FY 11-12. In FY 08-09 the percentage of Females served in Short Doyle/Medi-Cal facilities was at 46.9%, in FY 09-10 it was at 47.1%, and in FY 10-11 it was at 47.5%.

TABLE 23: PRIMARY LANGUAGE OF CONSUMERS SERVED IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY THRESHOLD LANGUAGE FY 2011 - 2012

Service Area (SA)	Armen-ian	Cambod-ian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	4	2	2	8,818	2	3	6	1	1	878	7	1	9,741
Percent	0.0%	0.0%	0.0%	**90.1%**	0.0%	0.0%	0.1%	0.0%	0.0%	**9.0%**	0.1%	0.0%	100.0%
SA 2	1,069	23	14	19,939	303	79	29	19	105	6,732	94	52	28,705
Percent	**3.7%**	0.1%	0.0%	**68.7%**	**1.0%**	0.3%	0.1%	0.1%	0.4%	**23.2%**	0.3%	0.2%	100.0%
SA 3	41	33	377	19,644	8	52	273	113	3	4,900	39	288	26,152
Percent	0.2%	**0.1%**	**1.4%**	**74.3%**	0.0%	0.2%	**1.0%**	**0.4%**	0.0%	**18.5%**	0.1%	**1.1%**	100.0%
SA 4	213	162	133	30,956	51	609	118	55	129	9,081	120	184	42,596
Percent	**0.5%**	0.4%	**0.3%**	**71.7%**	0.1%	**1.4%**	0.3%	0.1%	**0.3%**	**21.0%**	0.3%	0.4%	100.0%
SA 5	8	0	2	7,827	37	17	9	2	14	890	9	3	8,995
Percent	0.1%	0.0%	0.0%	**85.7%**	**0.4%**	0.2%	0.1%	0.0%	0.2%	**9.7%**	0.1%	0.0%	100.0%
SA 6	7	3	10	23,573	2	44	18	4	5	7,141	8	16	30,912
Percent	0.0%	0.0%	0.0%	**75.5%**	0.0%	0.1%	0.1%	0.0%	0.0%	**22.9%**	0.0%	0.1%	100.0%
SA 7	6	54	7	15,108	6	55	33	12	2	6,163	27	9	21,577
Percent	0.0%	0.2%	0.0%	**69.3%**	0.0%	0.3%	0.2%	0.1%	0.0%	**28.3%**	0.1%	0.0%	100.0%
SA 8	5	725	16	26,059	7	133	34	26	5	5,833	103	271	33,451
Percent	0.0%	**2.1%**	0.0%	**77.1%**	0.0%	0.4%	0.1%	0.1%	0.0%	**17.3%**	0.3%	0.8%	100.0%
Total	1,317	986	544	136,582	402	962	490	219	251	38,785	389	804	183,654
Percent	0.7%	0.5%	0.3%	74.4%	0.2%	0.5%	0.3%	0.1%	0.1%	21.1%	0.2%	0.4%	100.0%

Note: SA Threshold Languages are in bold. 5,274 (2.9%) consumers served in Short Doyle/Medi-Cal (SD/MC) facilities reported "Other" as their primary language. 830 (0.4%) consumers served in SD/MC facilities reported their primary language as "Unknown." Arabic is a Countywide threshold language and is not included, N = 3,347 (0.2%).

Table 23 shows the primary language of consumers served by threshold language.

SA 1: 8,818 (90.1%) English speaking consumers were served and 878 (9.0%) Spanish speaking consumers were served.

SA 2: 1,069 (3.7%) Armenian speaking consumers were served; 19,939 (68.7%) English speaking consumers were served; 303 (1.0%) Farsi speaking consumers were served; and 6,732 (23.2%) Spanish speaking consumers were served.

SA 3: 33 (0.1%) Cambodian speaking consumers were served; 377 (1.4%) Cantonese speaking consumers were served; 19,644 (74.3%) English speaking consumers were served; 273 (1.0%) Mandarin speaking consumers were served; 113 (0.4%) Other Chinese speaking consumers were served; 4,900 (18.5%) Spanish speaking consumers were served; and 288 (1.1%) Vietnamese speaking consumers were served.

SA 4: 213 (0.5%) Armenian speaking consumers were served; 133 (0.3%) Cantonese speaking consumers were served; 30,956 (71.7%) English speaking consumers were served; 609 (1.4%) Korean speaking consumers were served; 129 (0.3%) Russian speaking consumers were served; and 9,081 (21.0%) Spanish speaking consumers were served.

SA 5: 7,827 (85.7%) English speaking consumers were served; 37 (0.4%) Farsi speaking consumers were served; and 890 (9.7%) Spanish speaking consumers were served.

SA 6: 23,573 (75.5%) English speaking consumers were served and 7,141 (22.9%) Spanish speaking consumers were served.

SA 7: 15,108 (69.3%) English speaking consumers were served and 6,163 (28.3%) Spanish speaking consumers were served.

SA 8: 725 (2.1%) Cambodian speaking consumers were served; 26,059 (77.1%) English speaking consumers were served; and 5,833 (17.3%) Spanish speaking consumers were served.

Demographic Needs Assessment for Consumers Served In Outpatient Short Doyle/Medi-Cal Facilities by Service Area

Service Area 1

FIGURE 14: TOTAL POPULATION BY ETHNICITY
CY 2011 - SA 1 (N = 386,526)

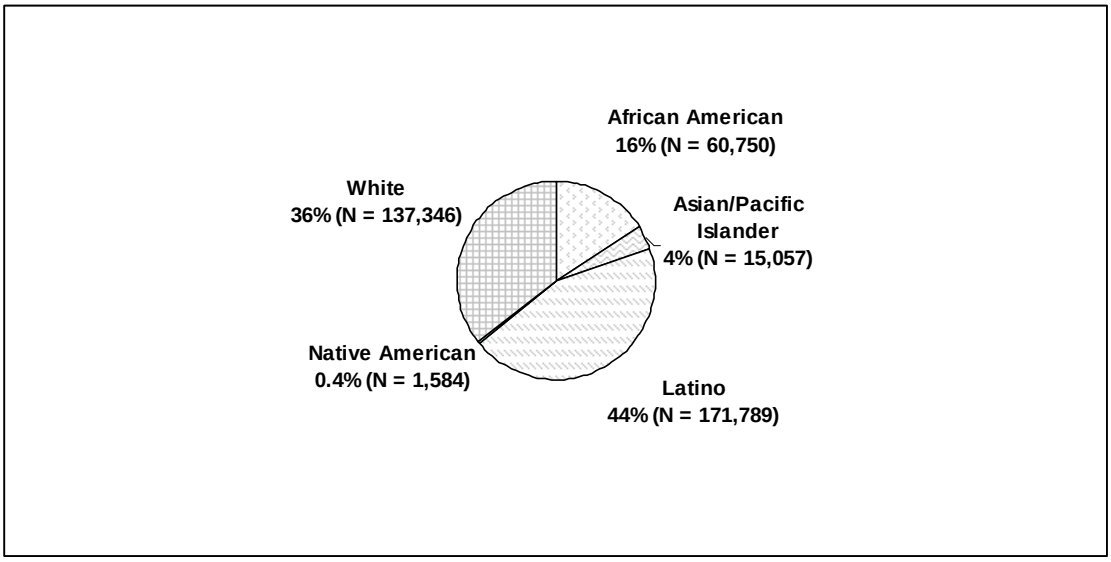


FIGURE 15: TOTAL POPULATION BY AGE GROUP
CY 2011 - SA 1 (N = 386,526)

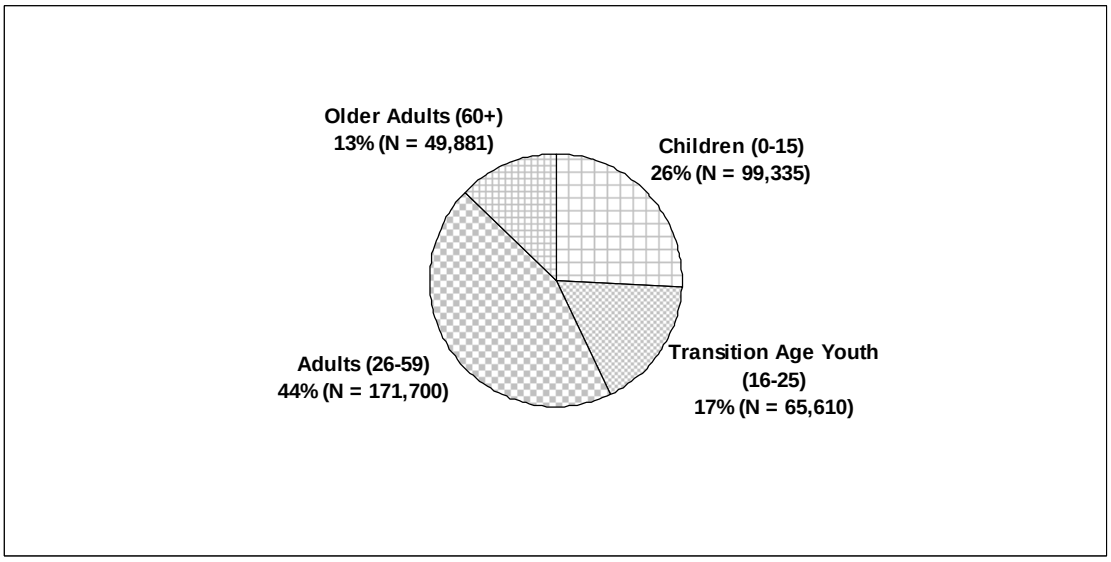
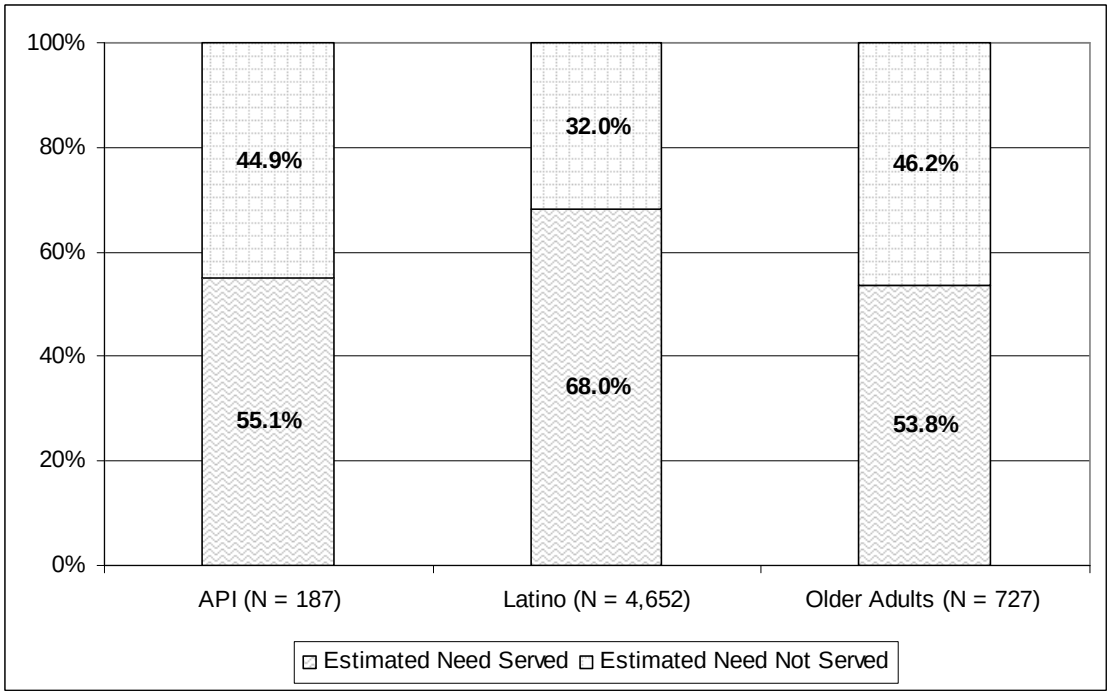


FIGURE 16: PENETRATION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND AGE GROUP FY 2011 - 2012 - SA 1

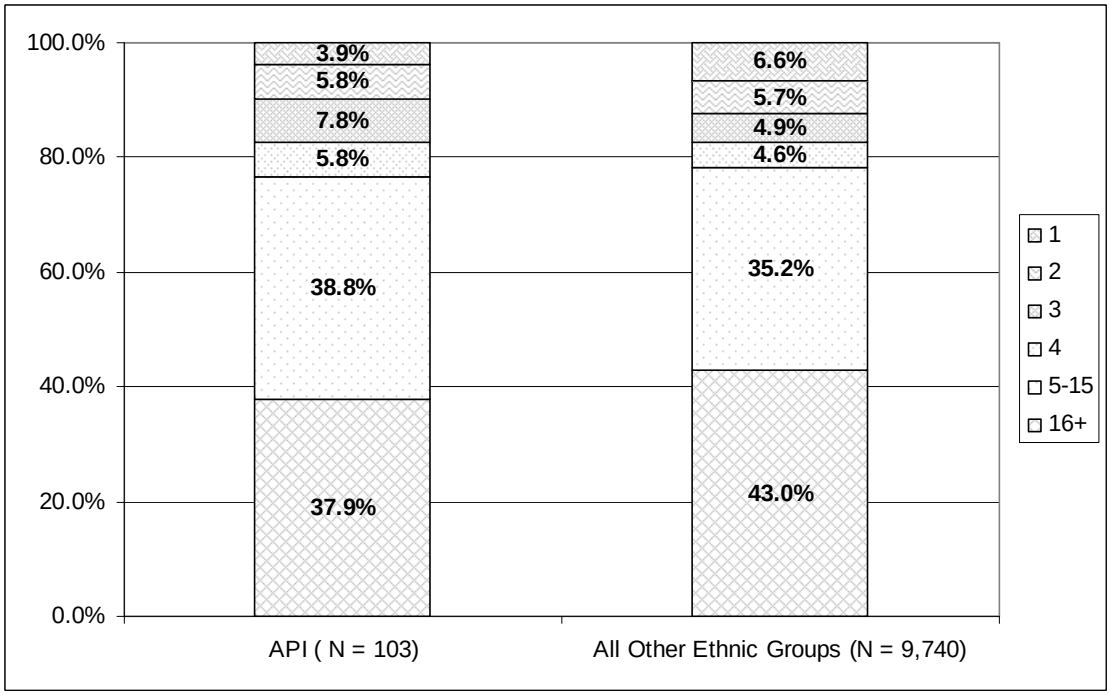


API = Asian/Pacific Islander

Figure 16 shows that among all ethnic groups reported, the API and the Latino populations have an estimated unmet need for services in SA 1. The Penetration Rate is calculated as the number of consumers served in Outpatient Short Doyle/Medi-Cal facilities divided by the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 1 represent 55.1%, while 44.9% are estimated to remain in need of services; Latino consumers served in SA 1 represent 68.0% while 32.0% are estimated to remain in need of services.

Figure 16 also shows that among all age groups reported, the Older Adult population has an estimated unmet need for services in SA 1. Using Penetration Rate to conduct a needs assessment indicates that Older Adult consumers served in SA 1 represent 53.8%, while 46.2% are estimated to remain in need of services.

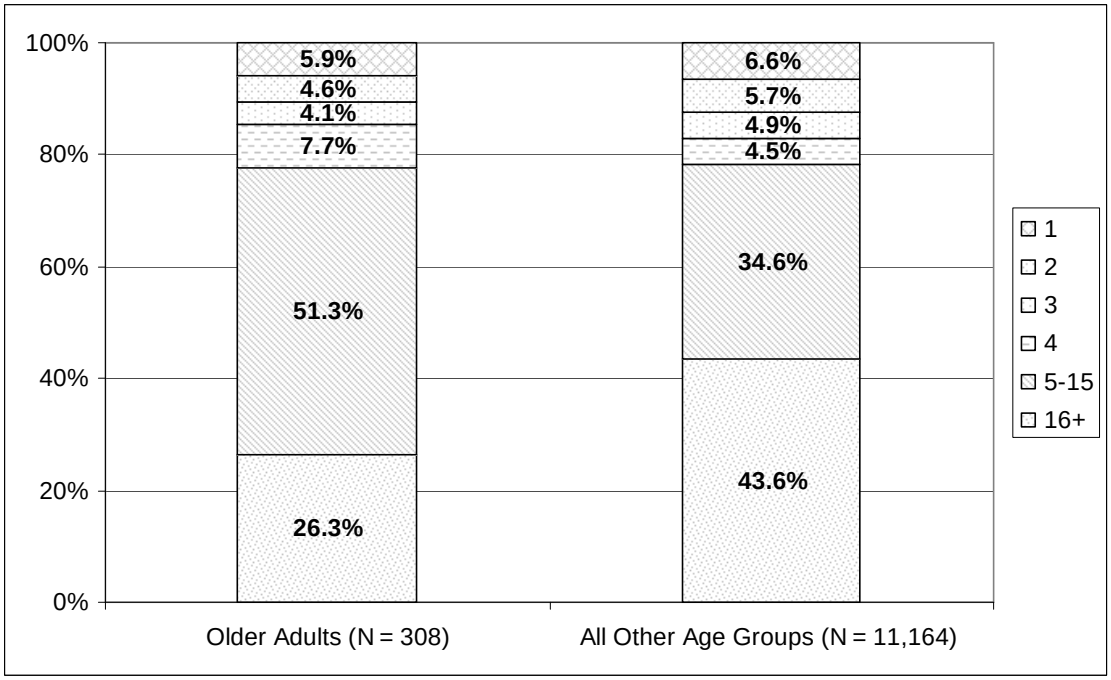
FIGURE 17: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY
FY 2011 - 2012 - SA 1



Retention Rate = Number of Approved Outpatient Claims

Figure 17 shows that among API consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 1, 23.3% (3.9 + 5.8 + 7.8 + 5.8 = 23.3%) received four or fewer services compared to 21.8% (6.6 + 5.7 + 4.9 + 4.6 = 21.8%) for all other ethnic groups; 38.8% received 5 to 15 services compared to 35.2% for all other ethnic groups; and 37.9% received 16 or more services compared to 43.0% for all other ethnic group consumers that received Outpatient Services in SA 1.

FIGURE 18: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP
FY 2011 - 2012 - SA 1



Retention Rate = Number of Approved Outpatient Claims

Figure 18 shows that among the Older Adult consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 1, 22.3% (5.9 + 4.6 + 4.1 + 7.7 = 22.3%) received four or fewer services compared to 21.7% (6.6 + 5.7 + 4.9 + 4.5 = 21.7%) for all other age groups; 51.3% received 5 to 15 services compared to 34.6% for all other age groups; and 26.3% received 16 or more services compared to 43.6% for all other age group consumers that received Outpatient services in SA 1.

Service Area 2

FIGURE 19: TOTAL POPULATION BY ETHNICITY
CY 2011 - SA 2 (N = 2,136,581)

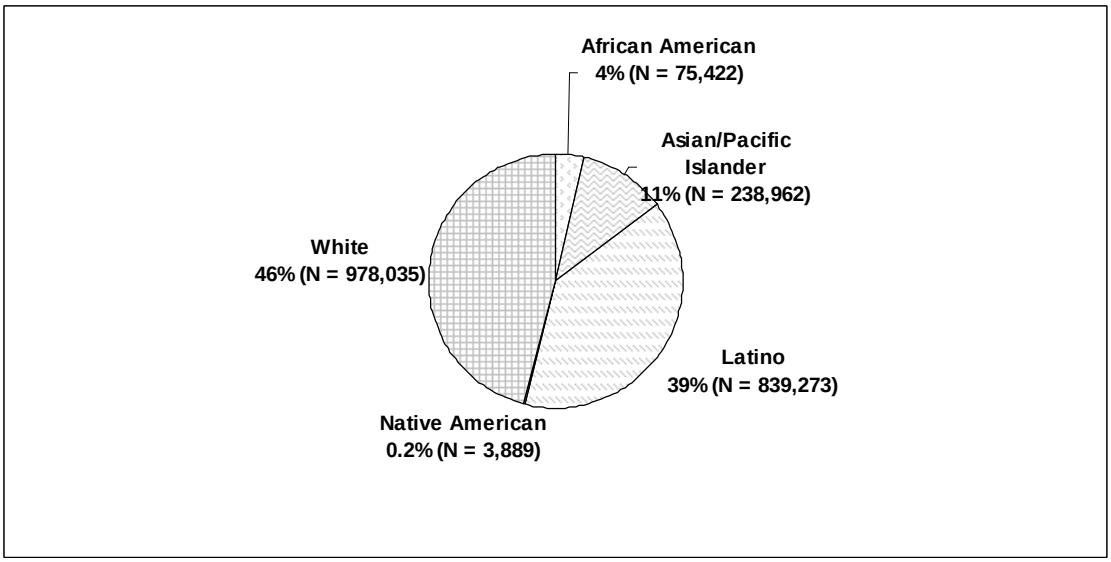


FIGURE 20: TOTAL POPULATION BY AGE GROUP
CY 2011 - SA 2 (N = 2,136,581)

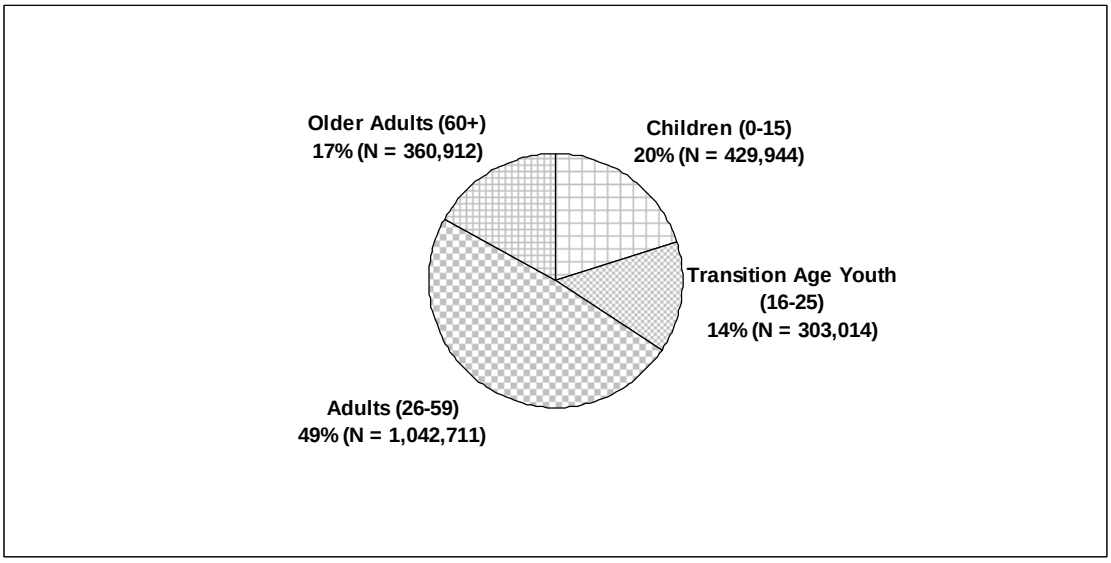
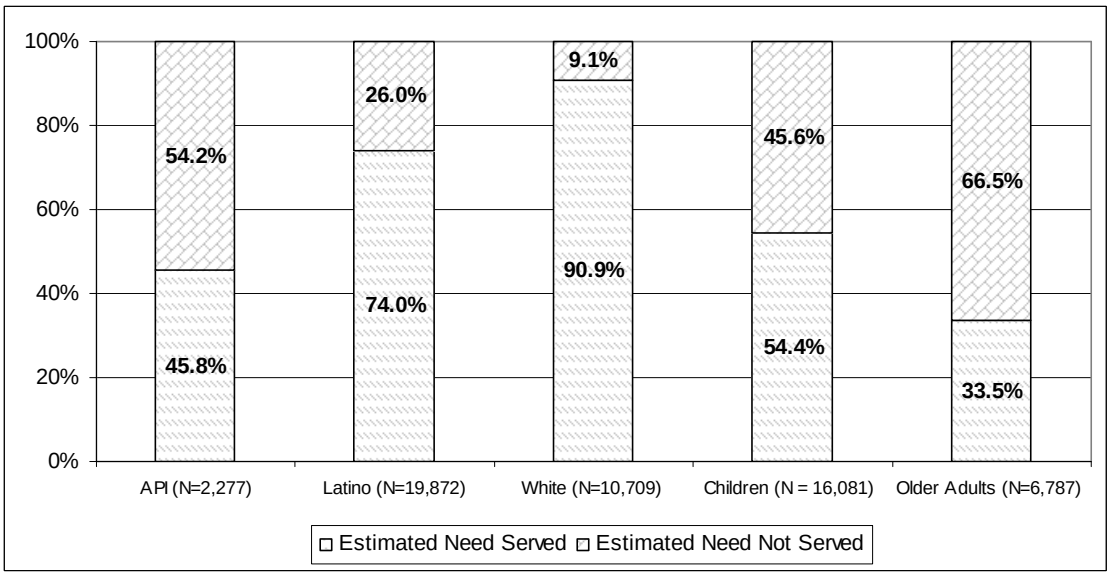


FIGURE 21: PENETRATION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND AGE GROUP FY 2011 - 2012 - SA 2

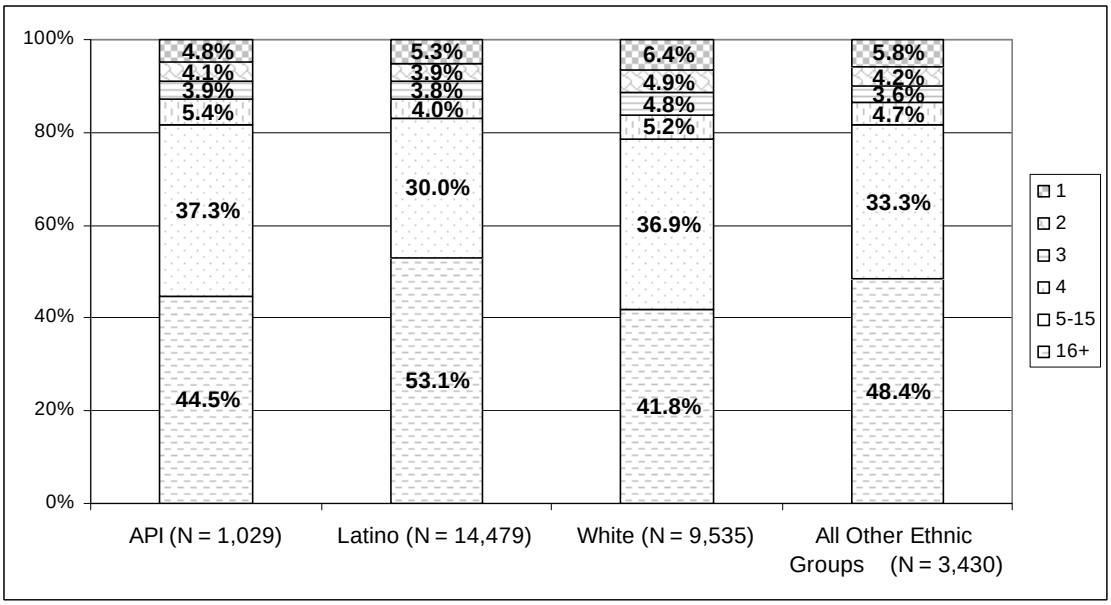


API = Asian/Pacific Islander

Figure 21 shows that among all ethnic groups reported, the API, Latino, and White populations have an estimated unmet need for services in SA 2. The Penetration Rate is calculated as the number of consumers served in Outpatient Short Doyle/Medi-Cal facilities divided by the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 2 represent 45.8%, while 54.2% are estimated to remain in need of services; Latino consumers served in SA 2 represent 74.0%, while 26.0% are estimated to remain in need of services; White consumers served in SA 2 represent 90.9%, while 9.1% are estimated to remain in need of services.

Figure 21 also shows that among all age groups reported, the Child and Older Adult populations have an estimated unmet need for services in SA 2. Using Penetration Rate to conduct a needs assessment indicates that Children served in SA 2 represent 54.4%, while 45.6% are estimated to remain in need of services; Older Adult consumers served in SA 2 represent 33.5%, while 66.5% are estimated to remain in need of services.

FIGURE 22: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY
FY 2011 - 2012 - SA 2

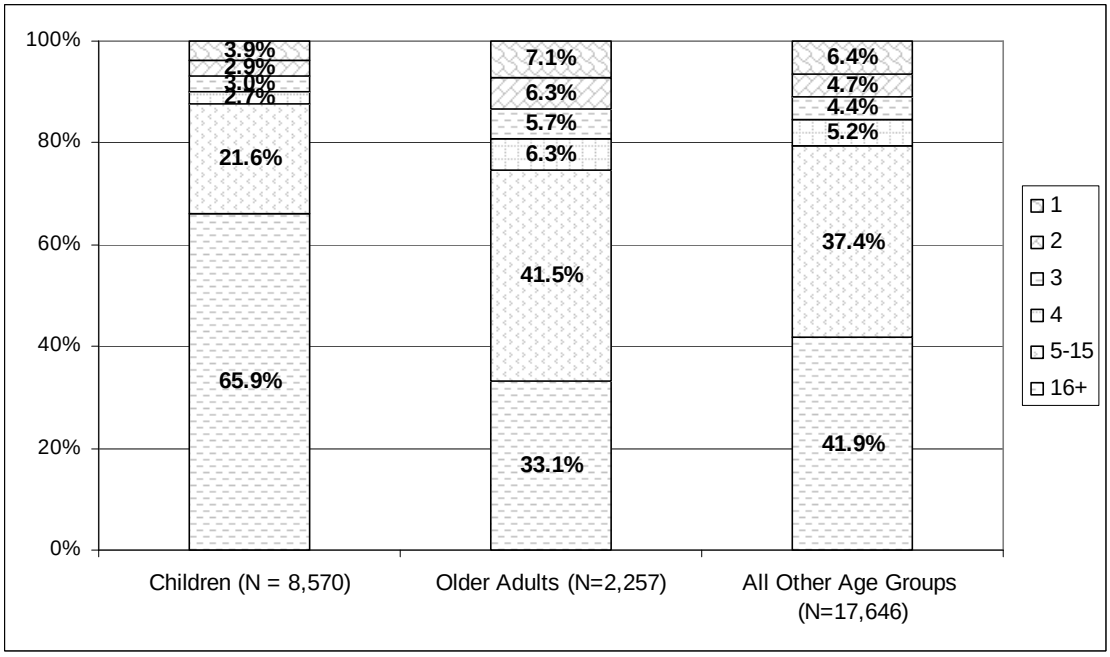


API = Asian/Pacific Islander, Retention Rate = Number of Approved Outpatient Claims

Figure 22 shows that among the API consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 2, 18.2% (4.8 + 4.1 + 3.9 + 5.4 = 18.2%) received four or fewer services as compared to 17.0% (4.0 + 3.8 + 3.9 + 5.3 = 17.0%) for Latinos; compared to 21.3% (5.2 + 4.8 + 4.9 + 6.4 = 21.3%) for Whites; and compared to 18.7% (5.8 + 4.2 + 3.6 + 4.7 = 18.3%) for all other ethnic groups.

Figure 22 also shows that among the API consumers served in SA 2, 37.3% received 5 to 15 services and 44.5% received 16 or more services; as compared to Latinos of which 30.0% received 5 to 15 services, and 53.1% received 16 or more services; as compared to Whites of which 36.9% received 5 to 15 services, and 41.8% received 16 or more services; and compared to all other ethnic groups of which 33.3% received 5 to 15 services, and 48.4% received 16 or more services.

FIGURE 23: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP
FY 2011 - 2012 - SA 2



Retention Rate = Number of Approved Outpatient Claims

Figure 23 shows that among Children served in Outpatient Short Doyle/Medi-Cal facilities in SA 2, 12.5% (3.9 + 2.9 + 3.0 + 2.7 = 12.5%) received four or fewer services compared to 25.4% (7.1 + 6.3 + 5.7 + 6.3 = 25.4%) for Older Adults, and compared to 20.7% (6.4 + 4.7 + 4.4 + 5.2 = 20.7%) for all other age groups.

Figure 23 also shows that among Children served, 21.6% received 5 to 15 services and 65.9% received 16 or more services; as compared with the Older Adults of which 41.5% received 5 to 15 services, and 33.1% received 16 or more services; and compared with all other age groups of which 37.4% received 5 to 15 services, and 41.9% received 16 or more services.

Service Area 3

FIGURE 24: TOTAL POPULATION BY ETHNICITY
CY 2011 - SA 3 (N = 1,752,126)

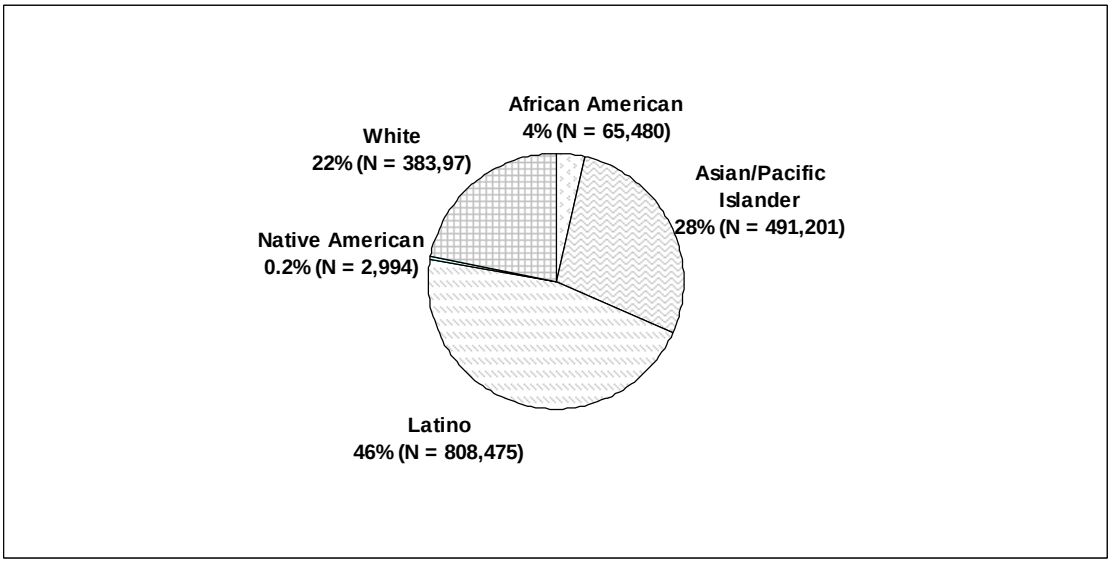


FIGURE 25: TOTAL POPULATION BY AGE GROUP
CY 2011 - SA 3 (N = 1,752,126)

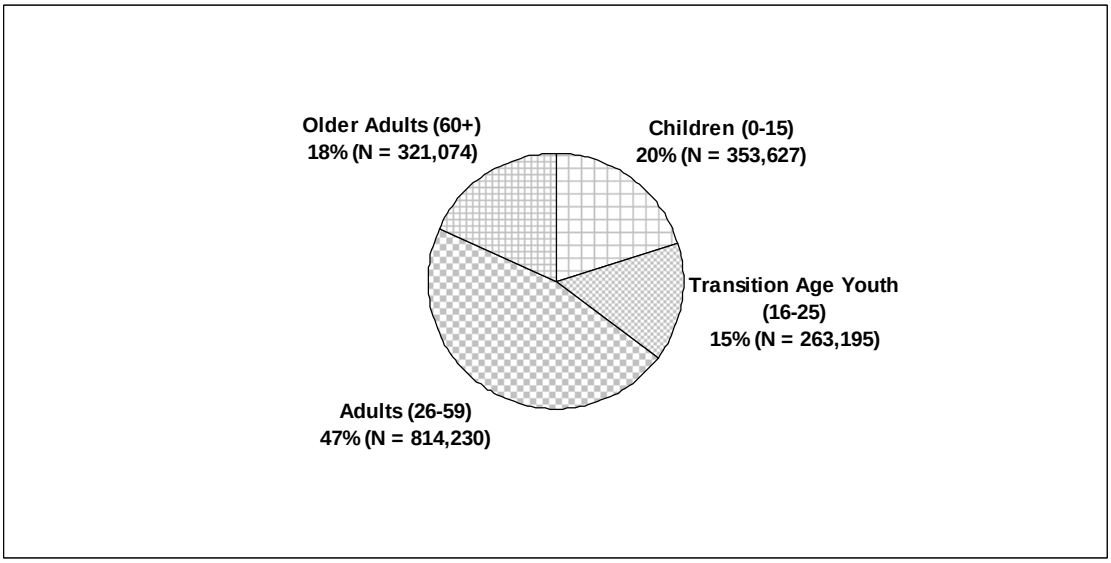
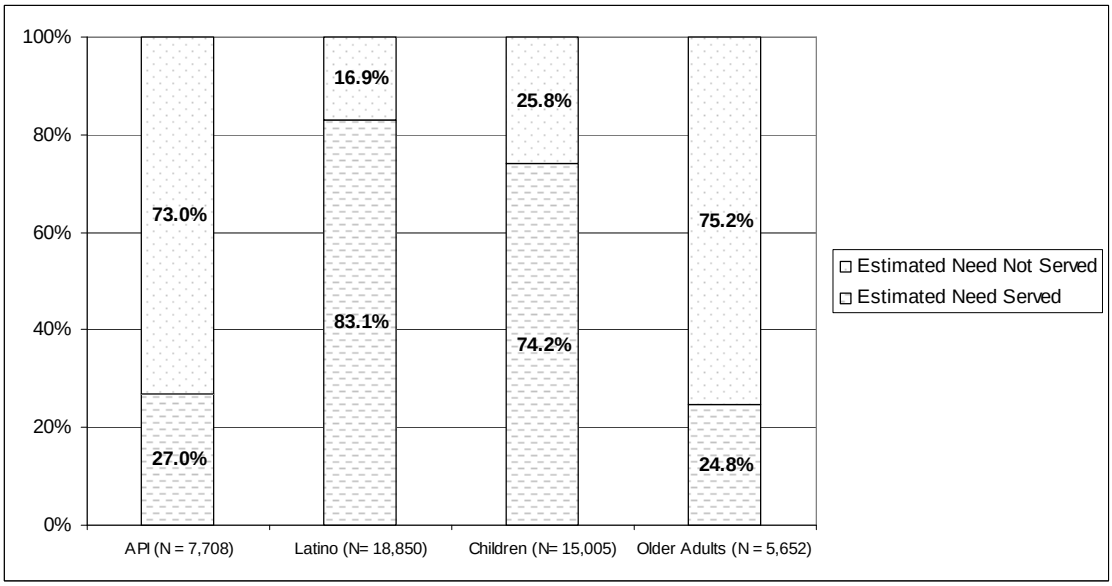


FIGURE 26: PENETRATION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND AGE GROUP FY 2011 - 2012 - SA 3

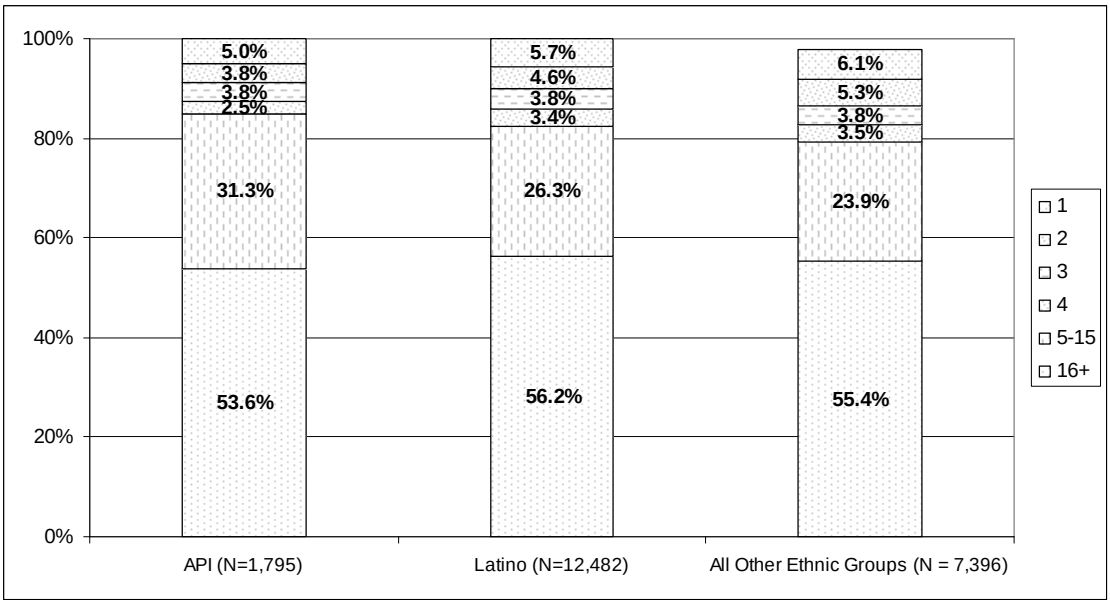


API = Asian/Pacific Islander

Figure 26 shows that among all ethnic groups reported, the API and the Latino populations have an estimated unmet need for services in SA 3. The Penetration Rate is calculated as the number of consumers served in Outpatient Short Doyle/Medi-Cal facilities divided by the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct needs assessment indicates that API consumers served in SA 3 represent 27.0%, while 73.0% are estimated to remain in need of services; Latino consumers served represent 83.1%, while 16.9% are estimated to remain in need of services.

Figure 26 also shows that among all age groups reported, the Child and Older Adult populations have an estimated unmet need for services in SA 3. Using Penetration Rate to conduct needs assessment Children served in SA 3 represent 74.2%, while 25.8% are estimated to remain in need of services and Older Adults served represent 24.8%, while 75.2% are estimated to remain in need of services.

FIGURE 27: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY
FY 2011 - 2012 - SA 3

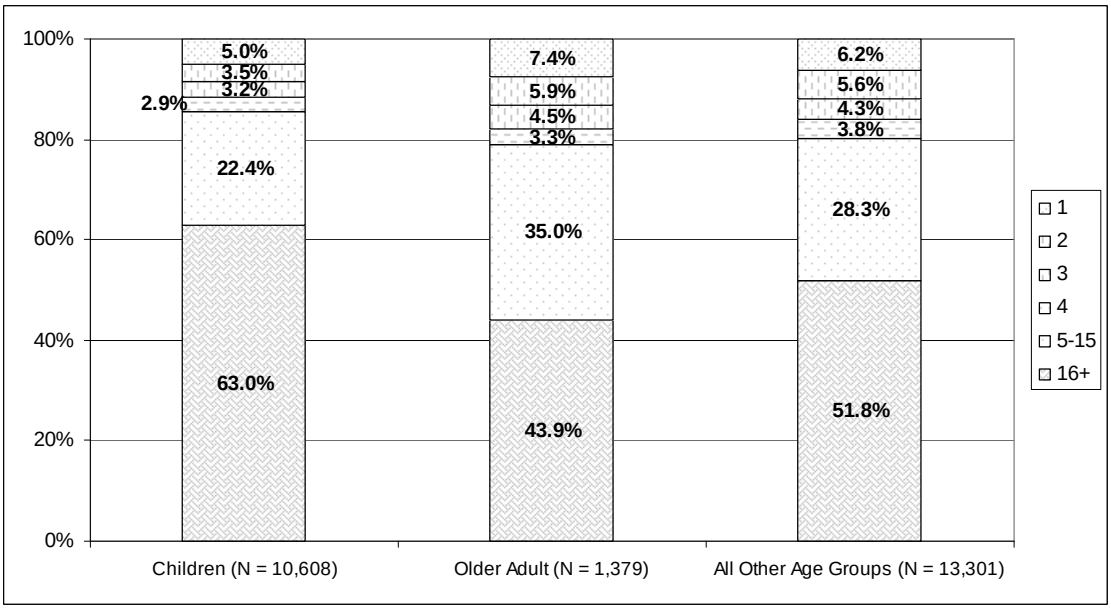


API = Asian/Pacific Islander

Figure 27 shows that among the API consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 3, 15.1% (2.5 + 3.8 + 3.8 + 5.0 = 15.1%) received four or fewer services; as compared to Latinos of which 17.5% (3.4 + 3.8 + 4.6 + 5.7 = 17.5%) received four or fewer services; and compared to all other ethnic groups of which 18.7% (3.5 + 3.8 + 5.3 + 6.1 = 18.7%) received four or fewer services.

Figure 27 also shows that among the API consumers served in SA 3, 31.3% received 5 to 15 services, and 53.6% received 16 or more services; as compared to Latinos of which 26.3% received 5 to 15 services, and 56.2% received 16 or more services; and compared to all other ethnic groups of which 23.9% received 5 to 15 services, and 55.4% received 16 or more services.

FIGURE 28: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP
FY 2011 - 2012 - SA 3



Retention Rate = Number of Approved Outpatient Claims

Figure 28 shows that among Children served in Outpatient Short Doyle/Medi-Cal facilities services in SA 3, 14.6% (5.0 + 3.5 + 3.2 + 2.9 = 14.6%) received four or fewer services; as compared to Older Adults of which 21.1% (3.3 + 4.5 + 5.9 + 7.4 = 21.1%) received four or fewer services; and compared to all other age groups of which 19.9% (6.2 + 5.6 + 4.3 + 3.8 = 19.9%) received four or fewer services.

Figure 28 also shows that among Children served, 22.4% received 5 to 15 services and 63.0% received 16 or more services; as compared with the Older Adults of which 35.0% received 5 to 15 services, and 43.9% received 16 or more services; and compared with all other age groups of which 28.3% received 5 to 15 services, and 51.8% received 16 or more services.

Service Area 4

FIGURE 29: TOTAL POPULATION BY ETHNICITY
CY 2011 - SA 4 (N = 1,120,091)

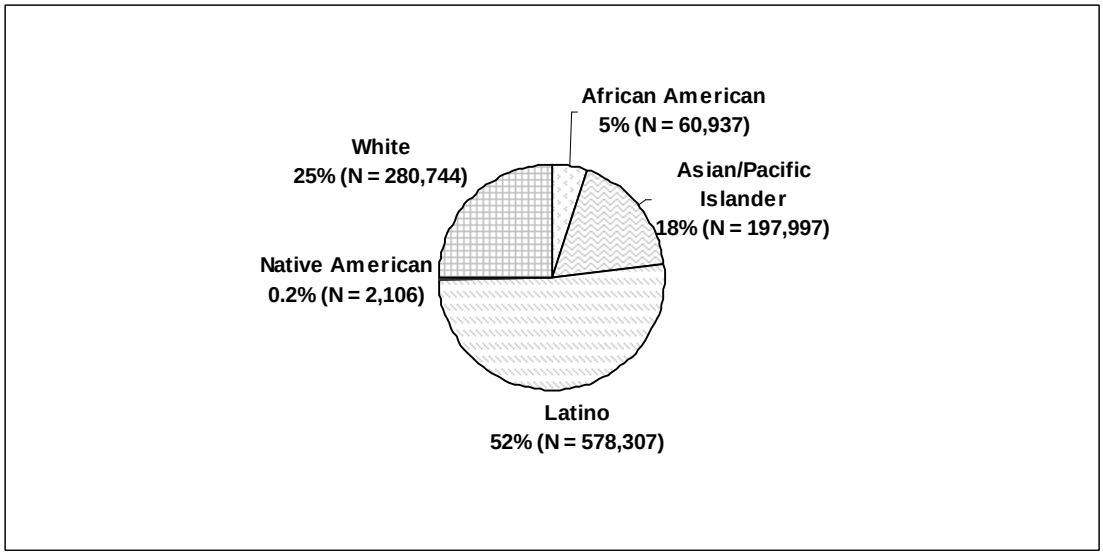


FIGURE 30: TOTAL POPULATION BY AGE GROUP
CY 2011 - SA 4 (N = 1,120,091)

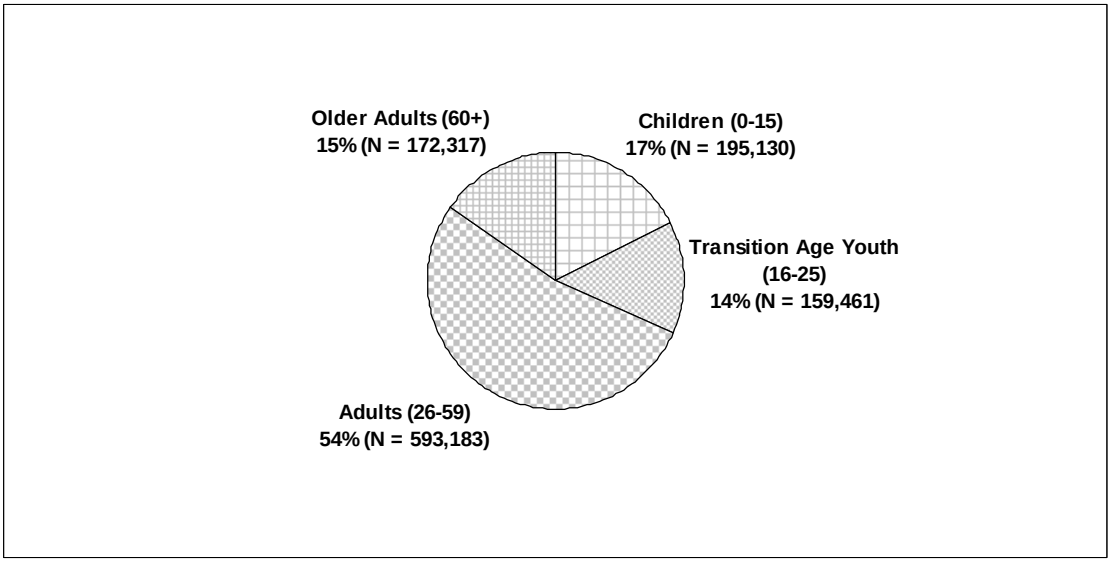
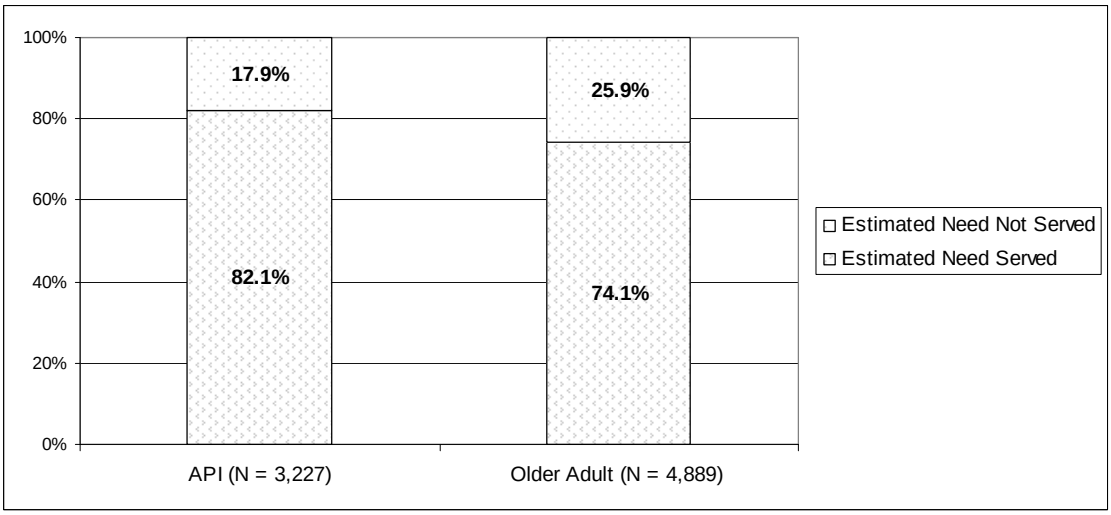


FIGURE 31: PENETRATION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND AGE GROUP
FY 2011 - 2012 - SA 4

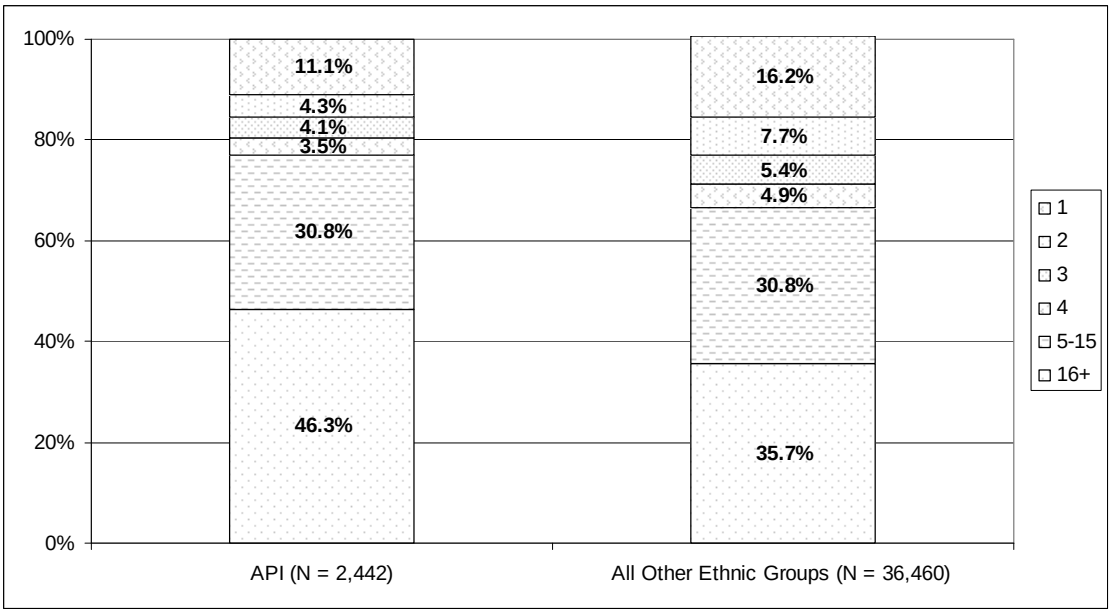


API = Asian/Pacific Islander

Figure 31 shows that among all ethnic groups reported, the API population has an estimated unmet need for services in SA 4. The Penetration Rate is calculated as the number of consumers served in Outpatient Short Doyle/Medi-Cal facilities divided by the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct needs assessment indicates API consumers served in SA 4 represent 82.1%, while 17.9% are estimated to remain in need of services.

Figure 31 also shows that among all age groups reported, the Older Adult population has an estimated unmet need for services in SA 4. Using Penetration Rate to conduct a needs assessment indicates that Older Adult consumers served in SA 4 represent 74.1%, while 25.9% are estimated to remain in need of services.

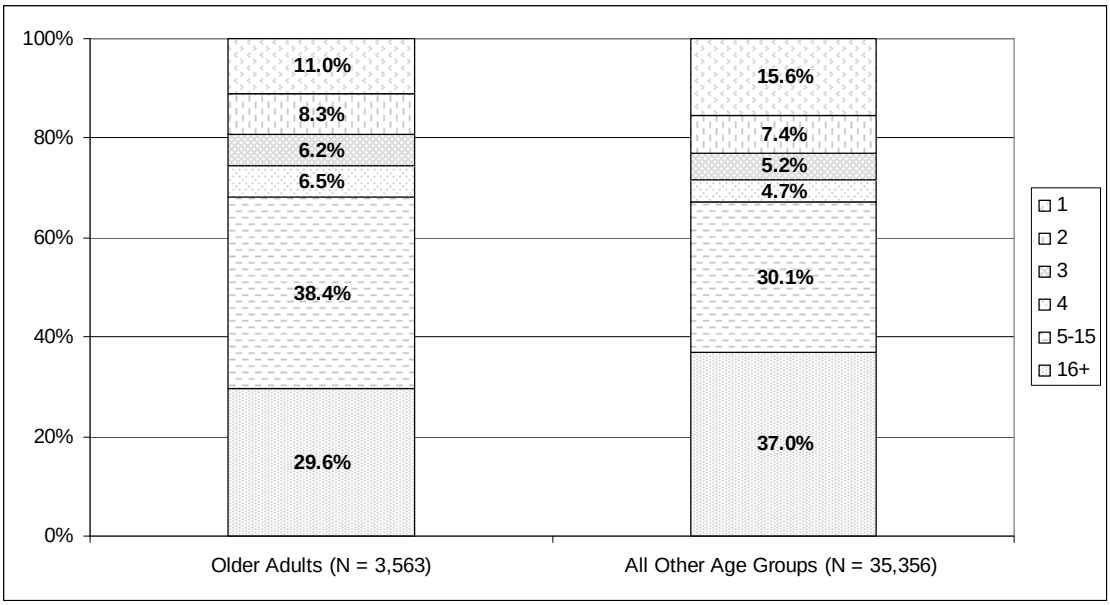
FIGURE 32: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY
FY 2011 - 2012 - SA 4



API = Asian/Pacific Islander, Retention Rate = Number of Approved Outpatient Claims

Figure 32 shows that among API consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 4, 23.0% (3.5 + 4.1 + 4.3 + 11.1 = 23.0%) received four or fewer services compared to 34.2% (16.2 + 7.7 + 5.4 + 4.9 = 34.2%) for all other ethnic groups; 30.8% received 5 to 15 services compared to 30.8% for all other ethnic groups; and 46.3% received 16 or more services compared to 35.7% for all other ethnic groups that received Outpatient services in SA 4.

FIGURE 33: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP
FY 2011 - 2012 - SA 4



Retention Rate = Number of Approved Outpatient Claims

Figure 33 shows that among Older Adult consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 4, 32.0% (11.0 + 8.3 + 6.2 + 6.5 = 32.0%) received four or fewer services compared to 32.9% (15.6 + 7.4 + 5.2 + 4.7 = 32.9%) for all other age groups; 38.4% received 5 to 15 services compared to 30.1% for all other age groups; and 29.6% received 16 or more services compared to 37.0% for all other age groups that received Outpatient services in SA 4.

Service Area 5

FIGURE 34: TOTAL POPULATION AND POPULATION BY ETHNICITY CY 2011 - SA 5 (N = 637,129)

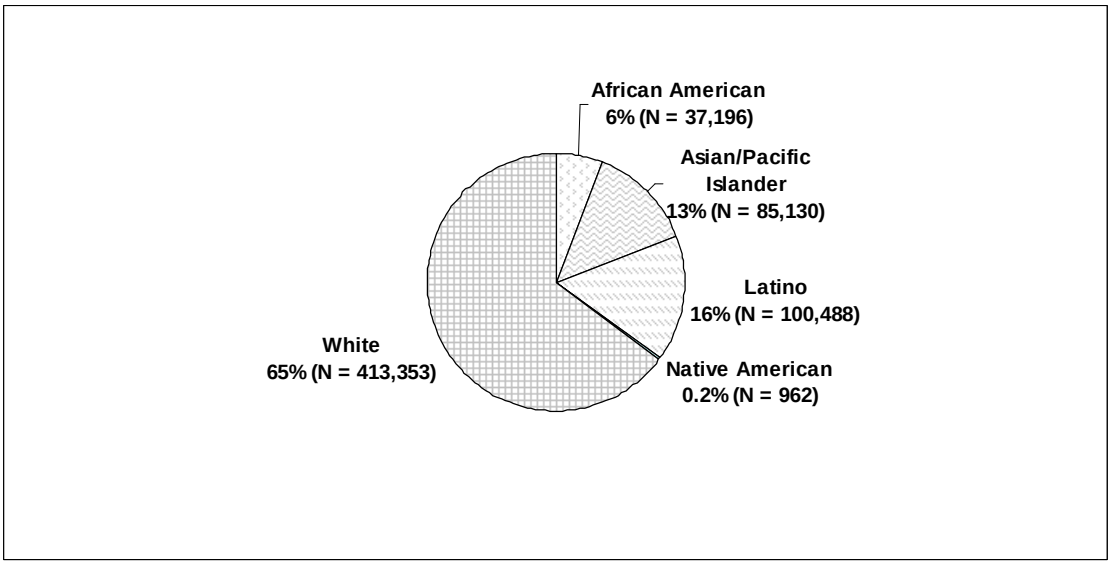


FIGURE 35: TOTAL POPULATION AND POPULATION BY AGE GROUP CY 2011 - SA 5 (N = 637,129)

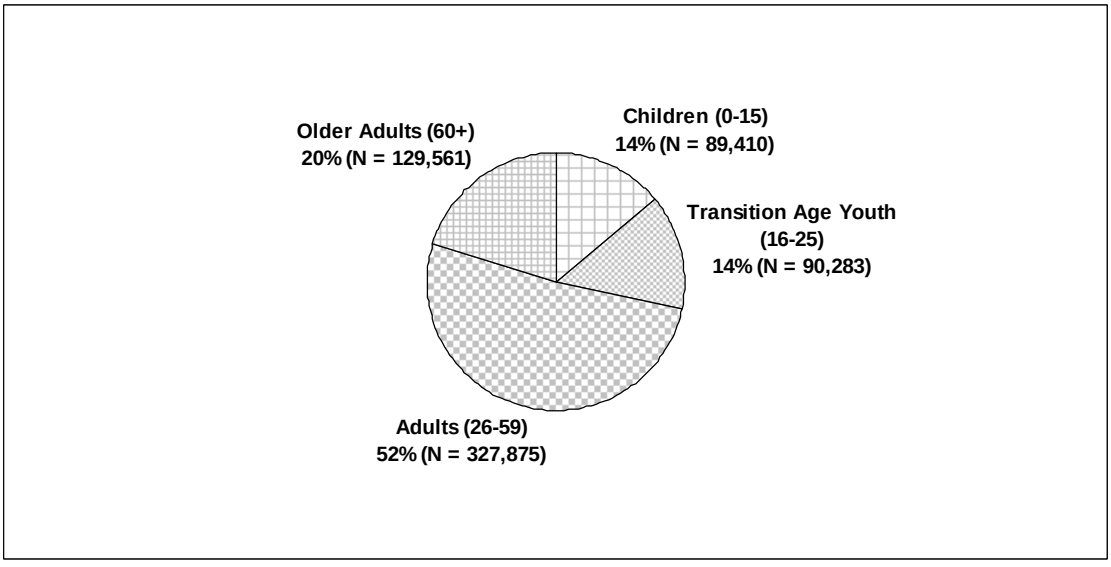


FIGURE 36: PENETRATION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND AGE GROUP FY 2011 - 2012 - SA 5

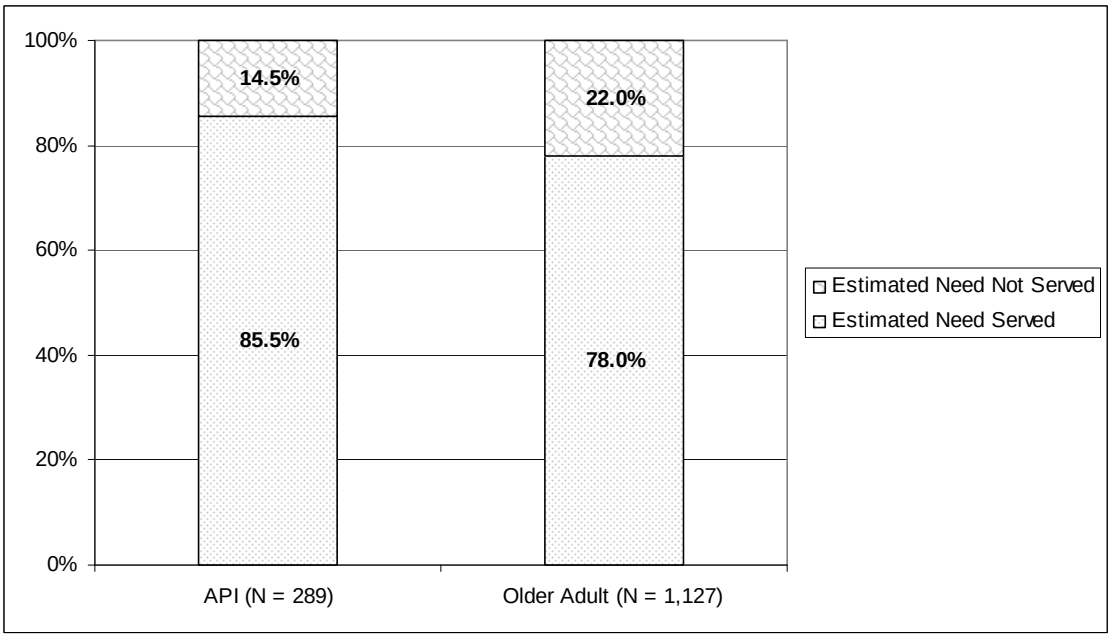


Figure 36 shows that among all ethnic groups reported, the API population has an estimated unmet need for services in SA 5. The Penetration Rate is calculated as the number of consumers served in Outpatient Short Doyle/Medi-Cal facilities divided by the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 5 represent 85.5%, while 14.5% are estimated to remain in need of services.

Figure 36 also shows that among all age groups, the Older Adult population has an estimated unmet need for services in SA 5. Using Penetration Rate to conduct a needs assessment indicates that Older Adult consumers served in SA 5 represent 78.0%, while 22.0% are estimated to remain in need of services.

FIGURE 37: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY
FY 2011 - 2012 - SA 5

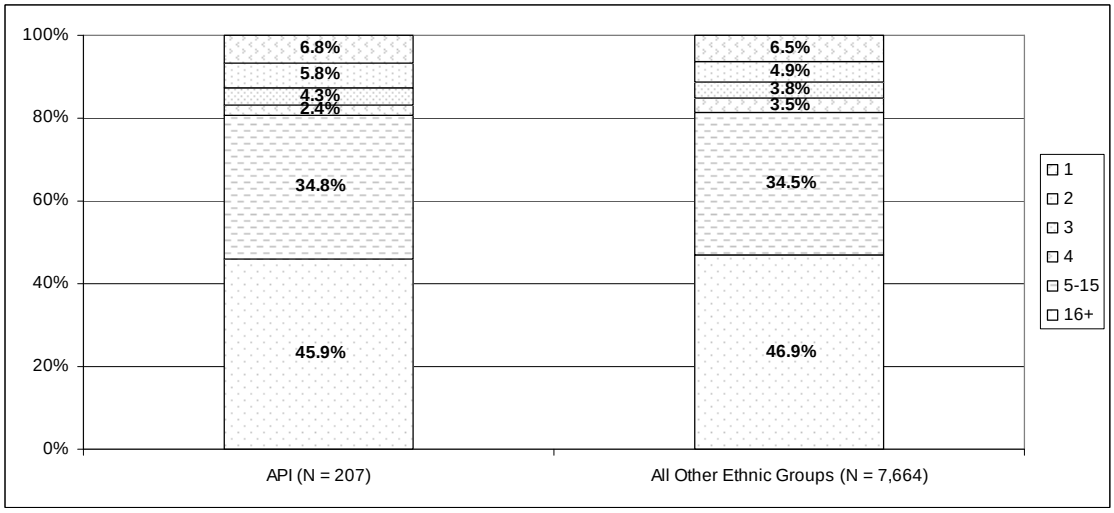
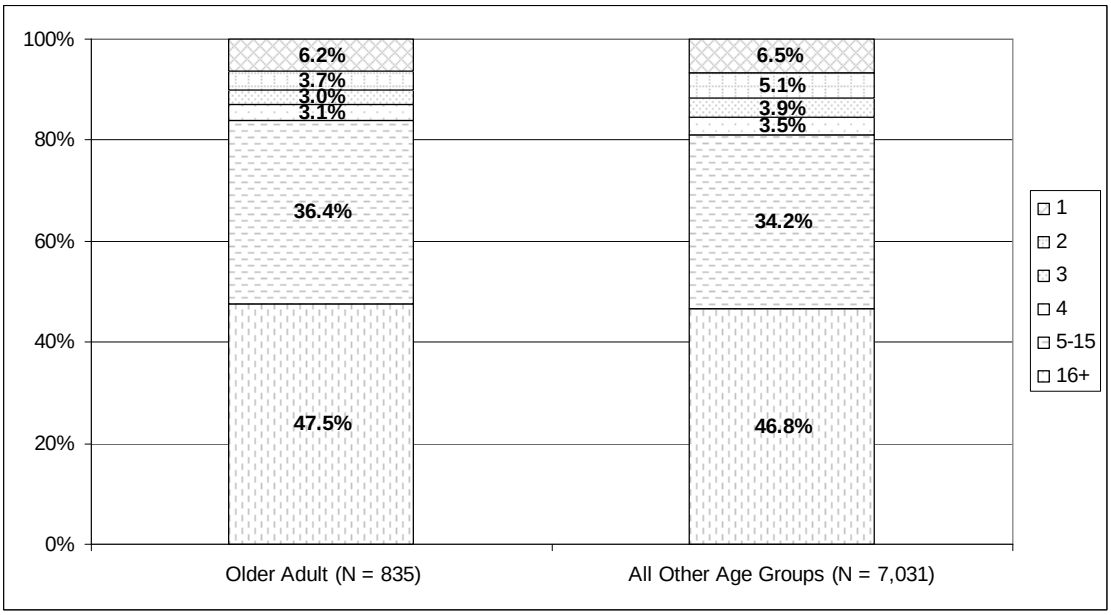


Figure 37 shows that among API consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 5, 19.3% (2.4 + 4.3 + 5.8 + 6.8 = 19.3%) received four or fewer services compared to 18.7% (6.5 + 4.9 + 3.8 + 3.5 = 18.7%) for all other age groups; 34.8% received 5 to 15 services compared to 34.5% for all other age groups; 45.9% received 16 or more services, compared to 46.9% for all other age groups that received Outpatient services in SA 5.

FIGURE 38: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP
FY 2011 - 2012 - SA 5



Retention Rate = Number of Approved Outpatient Claims

Figure 38 shows that among Older Adult consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 5, 16.0% (6.2 + 3.7 + 3.0 + 3.1 = 16.0%) received four or fewer services compared to 19.0% (6.5 + 5.1 + 3.9 + 3.5 = 19.0%) for all other age groups; 36.4% received 5 to 15 services compared to 34.2% for all other age groups; and 47.5% received 16 or more services, compared to 46.8% for all other age groups that received Outpatient services in SA 5.

Service Area 6

FIGURE 39: TOTAL POPULATION BY ETHNICITY
CY 2011 - SA 6 (N = 1,007,186)

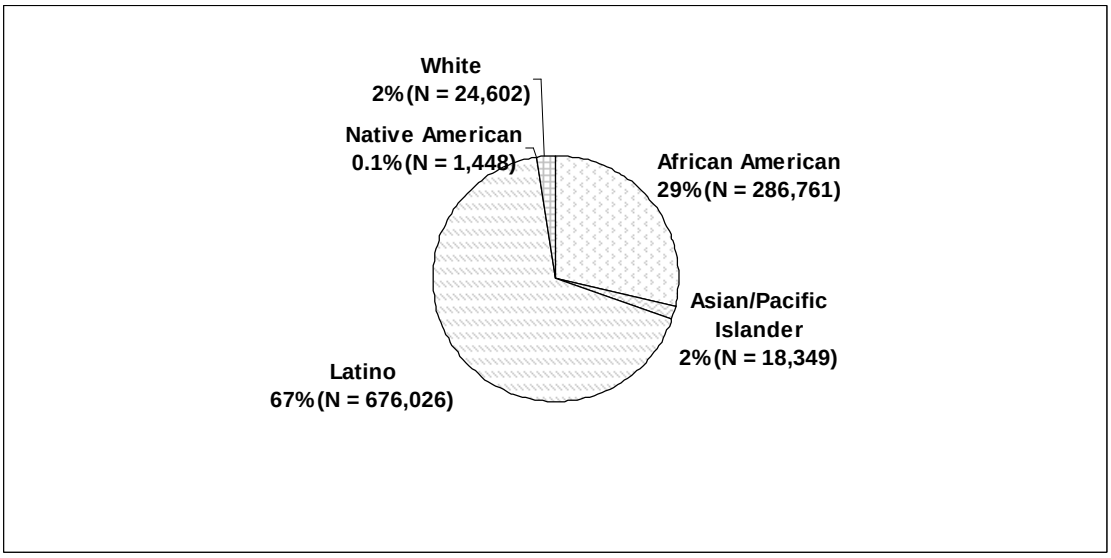


FIGURE 40: TOTAL POPULATION BY AGE GROUP
CY 2011 - SA 6 (N = 1,007,186)

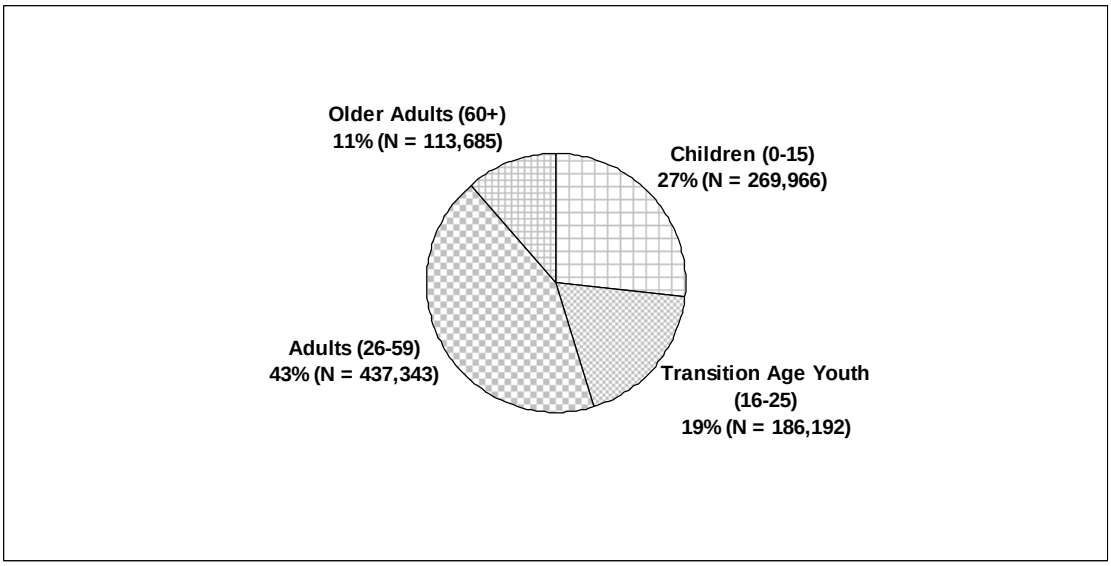
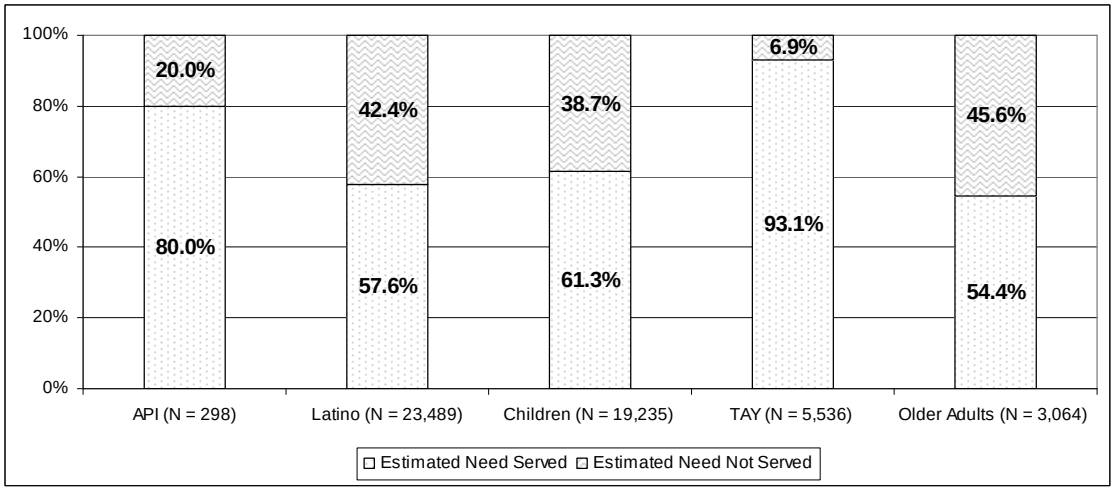


FIGURE 41: PENETRATION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND AGE GROUP FY 2011 - 2012 - SA 6

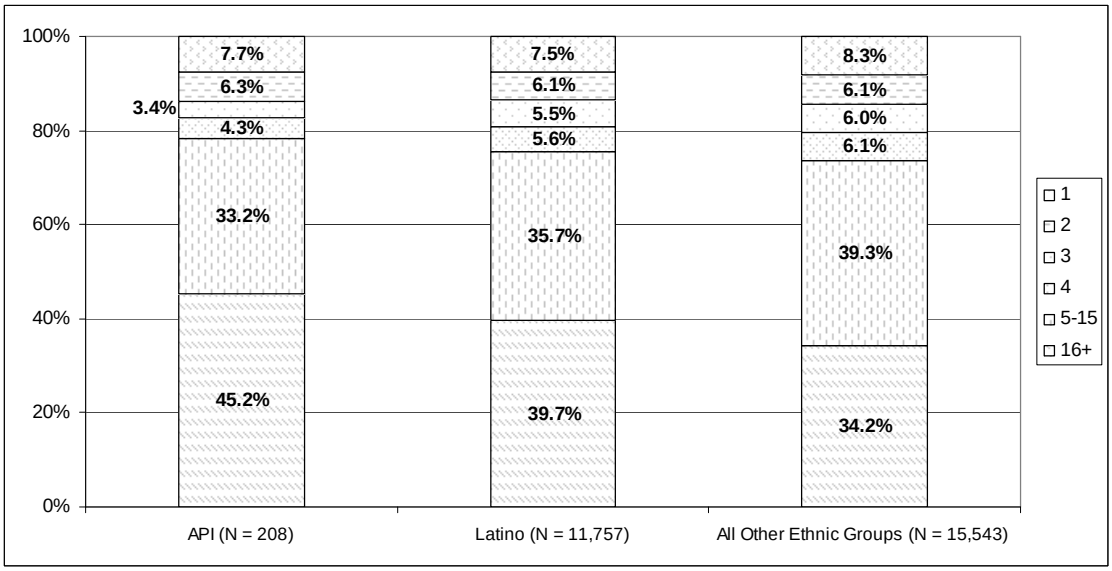


API = Asian/Pacific Islander

Figure 41 shows that among all ethnic groups reported, the API and Latino populations have an estimated unmet need for services in SA 6. The Penetration Rate is calculated as the number of consumers served in Outpatient Short Doyle/Medi-Cal facilities divided by the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 6 represent 80.0%, while 20.0% are estimated to remain in need of services; Latino consumers served in SA 6 represent 57.6%, while 42.4% are estimated to remain in need of services.

Figure 41 also shows that among all age groups reported, Children, TAY, and Older Adult populations have an estimated unmet need for services in SA 6. Using Penetration Rate to conduct a needs assessment indicates that Children served in SA 6 represent 61.3%, while 38.7% are estimated to remain in need of services; TAY consumers served in SA 6 represent 93.1% while 6.9% are estimated to remain in need of services; Older Adult consumers served in SA 6 represent 54.4%, while 45.6% are estimated to remain in need of services.

FIGURE 42: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY
FY 2011 - 2012 - SA 6

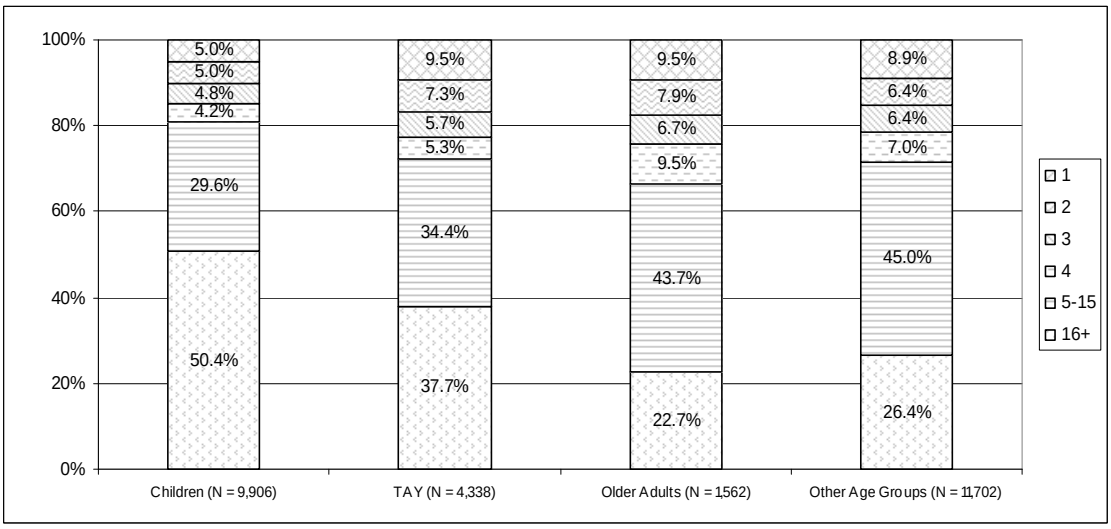


API = Asian/Pacific Islander, Retention Rate = Number of Approved Outpatient Claims

Figure 42 shows that among API consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 6, 21.7% (7.7 + 6.3 + 3.4 + 4.3 = 21.7%) received four or fewer services, as compared to Latinos of which 24.7% (7.5 + 6.1 + 5.5 + 5.6 = 24.7%) received four or fewer services, and compared to all other ethnic groups of which 26.5% (8.3 + 6.1 + 6.0 + 6.1 = 26.5%) received four or fewer services.

Figure 42 also shows that among API consumers served, 33.2% received 5 to 15 services and 45.2% received 16 or more services; as compared to Latinos of which 35.7% received 5 to 15 services, and 39.7% received 16 or more services; and compared to all other ethnic groups of which 39.3% received 5 to 15 services, and 34.2% received 16 or more services.

FIGURE 43: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP
FY 2011 - 2012 - SA 6



Retention Rate = Number of Approved Outpatient Claims

Figure 43 shows that among Children served in Outpatient Short Doyle/Medi-Cal facilities in SA 6, 19.8% (5.8 + 5.0 + 4.8 + 4.2 = 19.8%) received four or fewer services; compared to TAY of which 27.8% (9.5 + 7.3 + 5.7 + 5.3 = 27.8%) received four or fewer services; compared to Older Adults of which 33.6% (9.5 + 7.9 + 6.7 + 9.5 = 33.6%) received four or fewer services; and compared to all other age groups of which 28.7% (8.9 + 6.4 + 6.4 + 7.0 = 28.7%) received four or fewer services.

Figure 43 also shows that among Children served, 29.6% received 5 to 15 services and 50.4% received 16 or more services; compared to TAY of which 34.4% received 5 to 15 services and 37.7% received 16 or more services; compared to Older Adults of which 43.7% received 5 to 15 services, and 22.7% received 16 or more services; and all other ethnic groups of which 45.0% received 5 to 15 services, and 26.4% received 16 or more services.

Service Area 7

FIGURE 44: TOTAL POPULATION BY ETHNICITY
CY 2011 - SA 7 (N = 1,298,192)

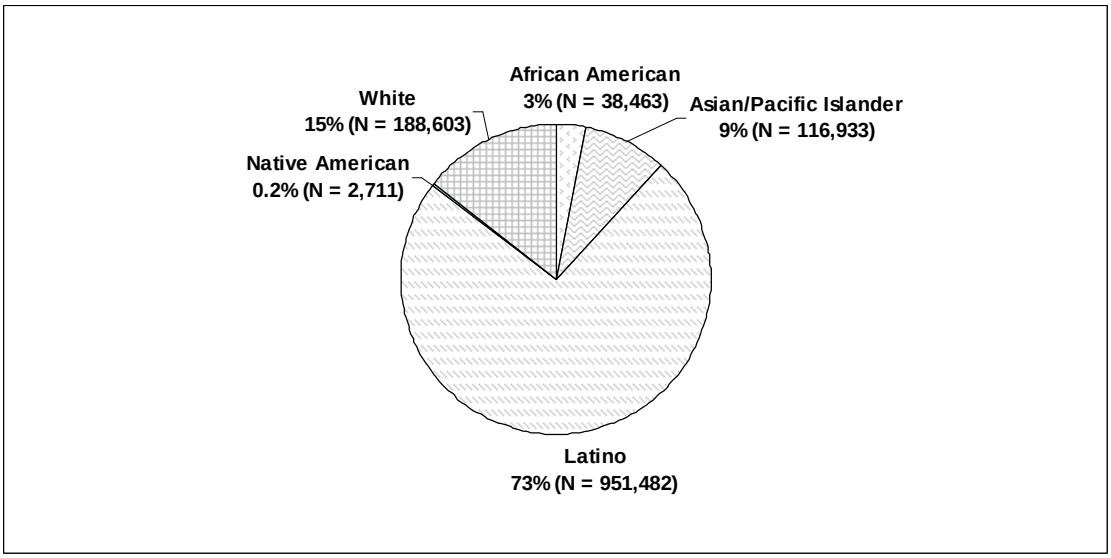


FIGURE 45: TOTAL POPULATION BY AGE GROUP
CY 2011 - SA 7 (N = 1,298,192)

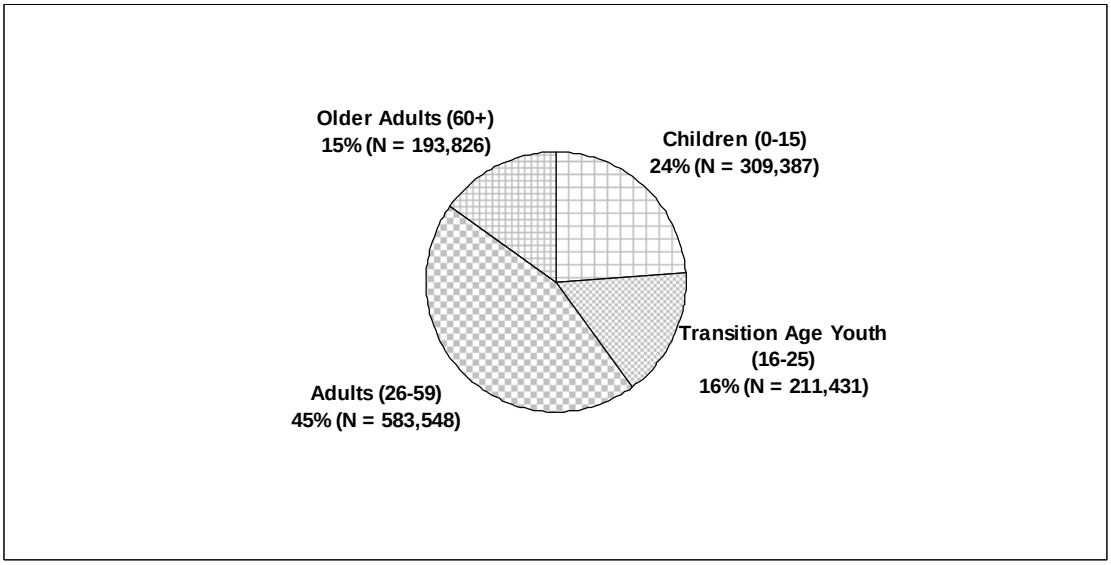
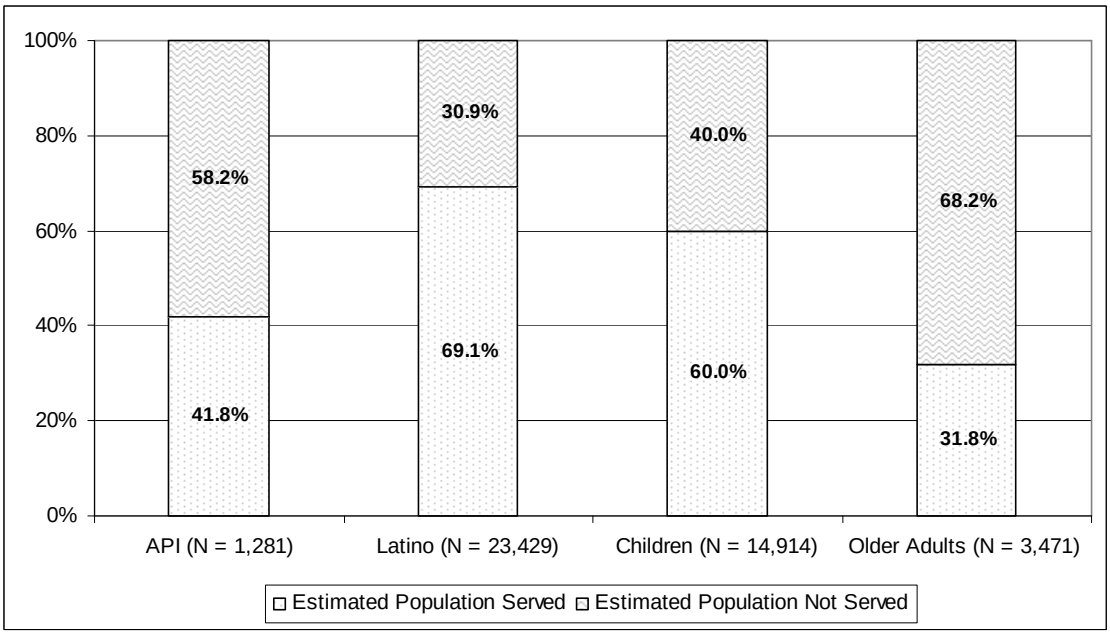


FIGURE 46: PENETRATION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND AGE GROUP
FY 2011 - 2012 - SA 7

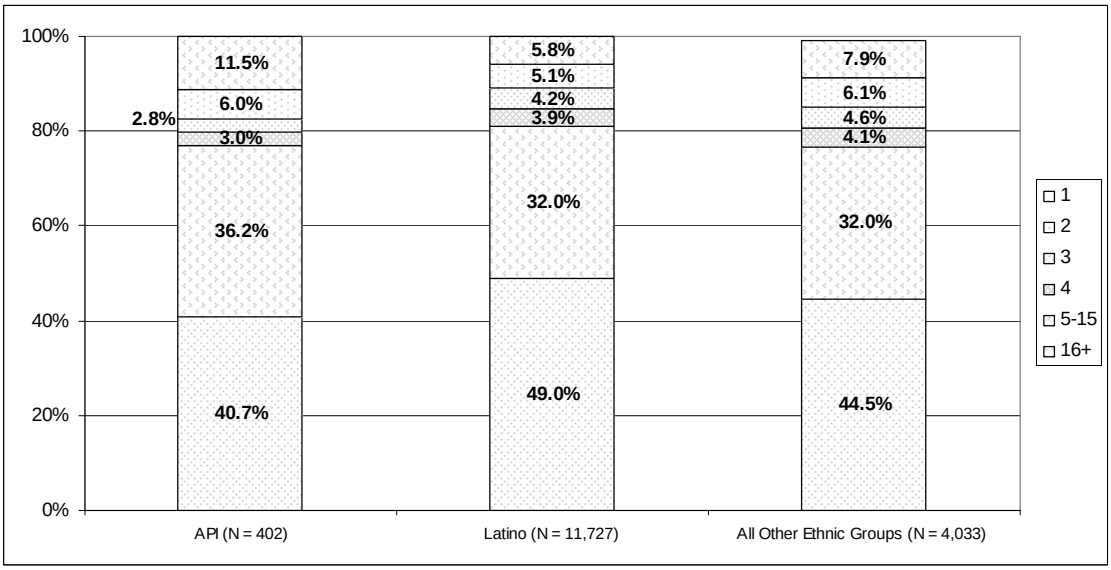


API = Asian/Pacific Islander

Figure 46 shows that among all ethnic groups reported, the API and the Latino populations have an estimated unmet need for services in SA 7. The Penetration Rate is calculated as the number of consumers served in Outpatient Short Doyle/Medi-Cal facilities divided by the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 7 represent 41.8%, while 58.2% are estimated to remain in need of services; Latino consumers served in SA 7 represent 69.1%, while 30.9% are estimated to remain in need of services.

Figure 46 also shows that among all age groups reported, the Child and Older Adult populations have an estimated unmet need for services in SA 7. Using Penetration Rate to conduct a needs assessment indicates that Children served in SA 7 represent 60.0%, while 40.0% are estimated to remain in need of services; Older Adult consumers served represent 31.8%, while 68.2% are estimated to remain in need of services.

FIGURE 47: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY
FY 2011 - 2012 - SA 7

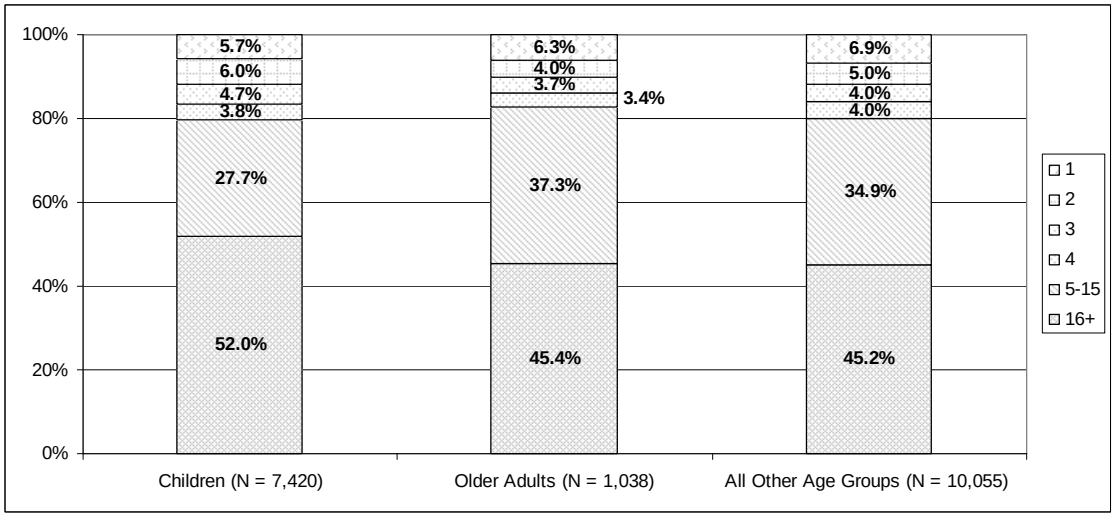


API = Asian/Pacific Islander, Retention Rate = Number of Approved Outpatient Claims

Figure 47 shows that among API consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 7, 23.3% (11.5 + 6.0 + 2.8 + 3.0 = 23.3%) received four or fewer services, compared to Latinos of which 19.0% (5.8 + 5.1 + 4.2 + 3.9 = 19.0%) received four or fewer services, and compared to all other ethnic groups of which 22.7% (7.9 + 6.1 + 4.6 + 4.1 = 22.7%) received four or fewer services.

Figure 47 also shows that among API consumers served, 36.2% received 5 to 15 services and 40.7% received 16 or more services; compared to Latinos of which 32.0% received 5 to 15 services, and 49.0% received 16 or more services; and compared to all other ethnic groups of which 32.0% received 5 to 15 services, and 44.5% received 16 or more services.

FIGURE 48: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP
FY 2011 - 2012 - SA 7



Retention Rate = Number of Approved Outpatient Claims

Figure 48 shows that among Children served in Outpatient Short Doyle/Medi-Cal facilities in SA 7, 20.2% (5.7 + 6.0 + 4.7 + 3.8 = 20.2%) received four or fewer services, compared to Older Adults of which 17.4% (6.3 + 4.0 + 3.7 + 3.4 = 17.4%) received four or fewer services, and compared to all other age groups of which 19.9% (6.9 + 5.0 + 4.0 + 4.0 = 19.9%) received four or fewer services.

Figure 48 also shows that among Children served, 27.7% received 5 to 15 services and 52.0% received 16 or more services; compared to Older Adults of which 37.3% received 5 to 15 services, and 45.4% received 16 or more services; and all other ethnic groups of which 34.9% received 5 to 15 services, and 45.2% received 16 or more services.

Service Area 8

FIGURE 49: TOTAL POPULATION BY ETHNICITY
CY 2011 - SA 8 (N = 1,528,363)

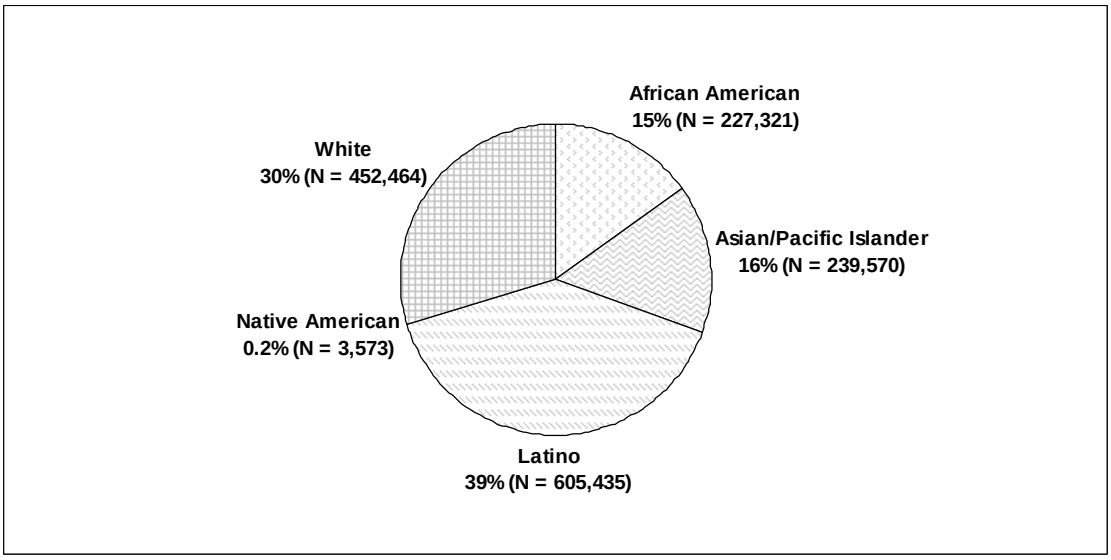


FIGURE 50: TOTAL POPULATION BY AGE GROUP
CY 2011 - SA 8 (N = 1,528,363)

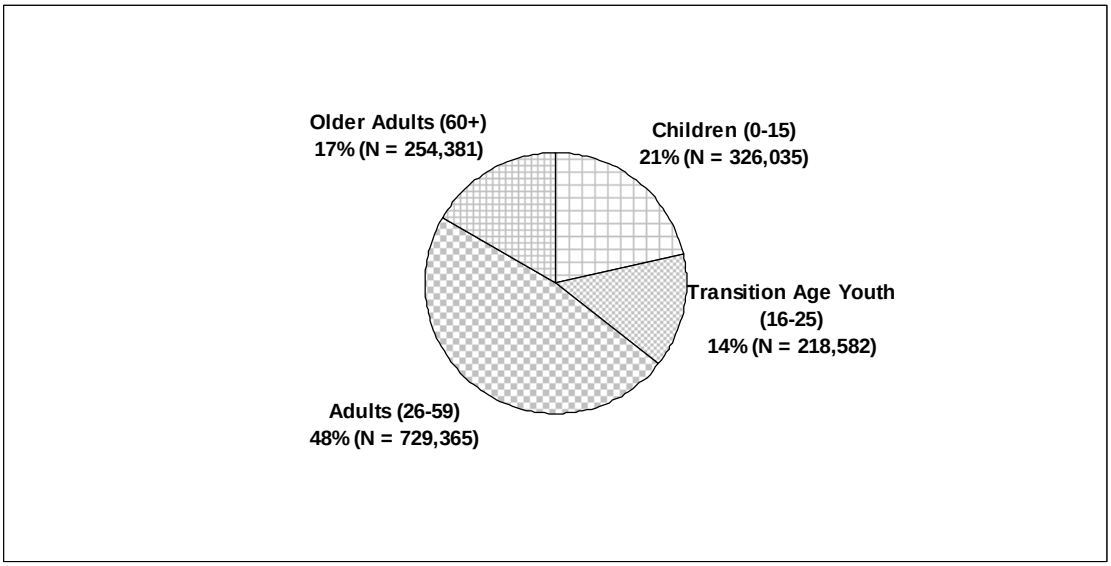
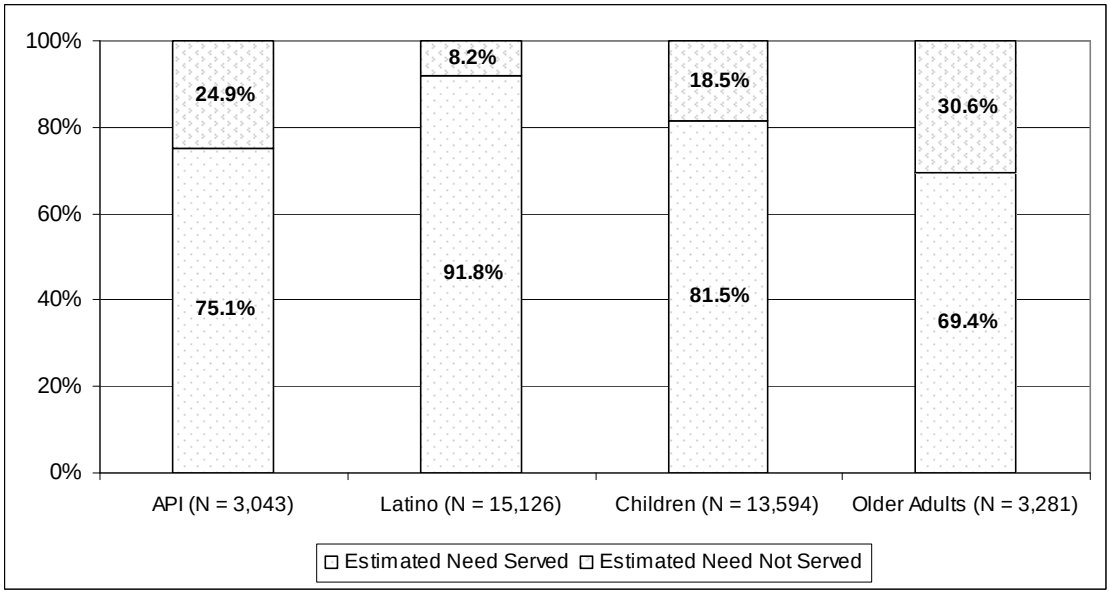


FIGURE 51: PENETRATION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY AND AGE GROUP FY 2011 - 2012 - SA 8

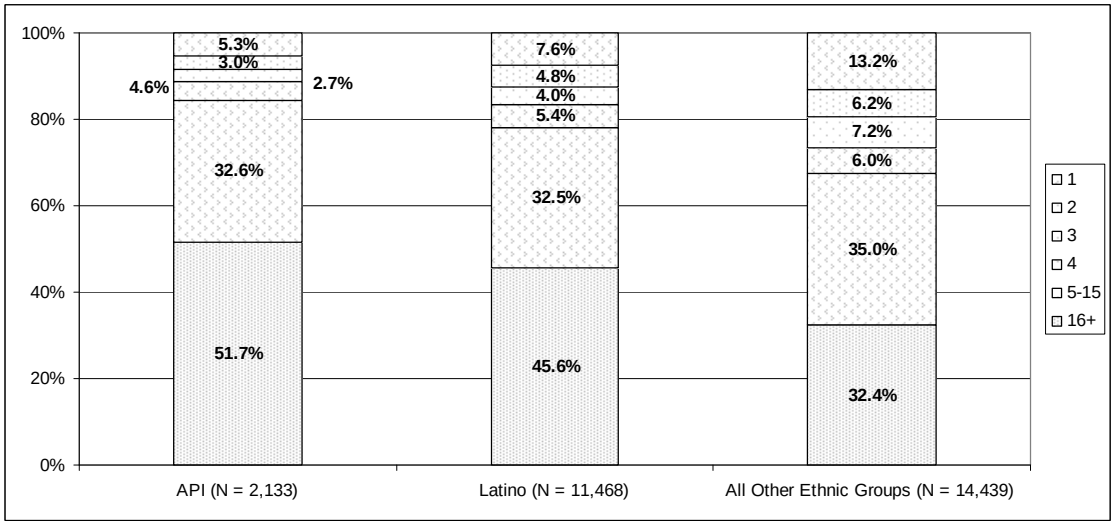


API = Asian/Pacific Islander

Figure 51 shows that among all ethnic groups reported, the API and the Latino populations have an estimated unmet need for services in SA 8. The Penetration Rate is calculated as the number of consumers served in Outpatient Short Doyle/Medi-Cal facilities divided by the total number of Medi-Cal enrollees with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI). Using Penetration Rate to conduct a needs assessment indicates that API consumers served in SA 8 represent 75.1%, while 24.9% are estimated to remain in need of services; Latino consumers served in SA 8 represent 91.8%, while 8.2% are estimated to remain in need of services.

Figure 51 also shows that among all age groups reported, the Child and Older Adult populations have an estimated unmet need for services in SA 8. Using Penetration Rate to conduct a needs assessment indicates that Children served in SA 8 represent 81.5%, while 18.5% are estimated to remain in need of services; Older Adult consumers served in SA 8 represent 69.4%, while 30.6% are estimated to remain in need of services.

FIGURE 52: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY ETHNICITY
FY 2011 - 2012 - SA 8

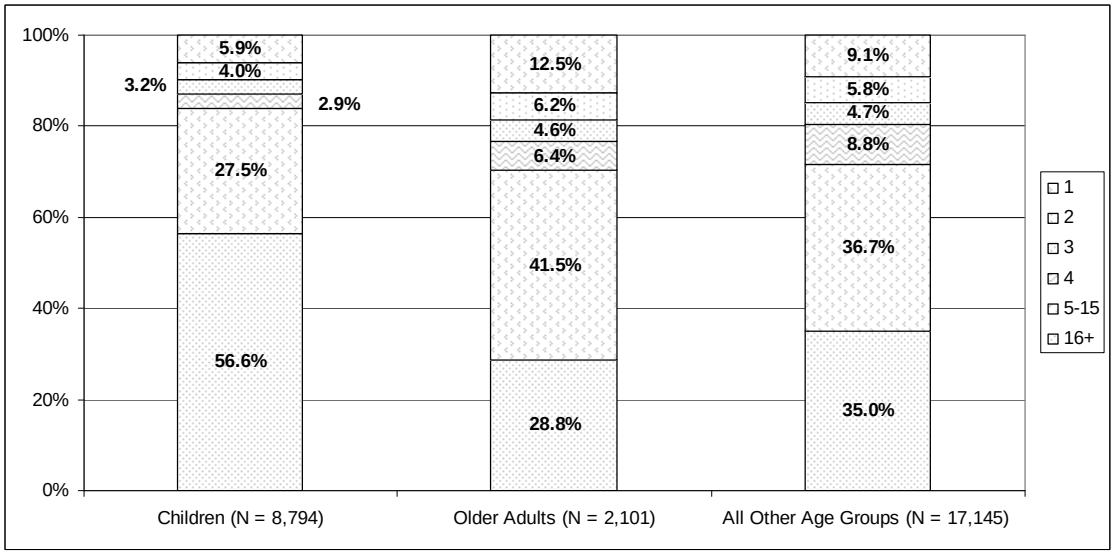


API = Asian/Pacific Islander, Retention Rate = Number of Approved Outpatient Claims

Figure 52 shows that among API consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 8, 15.6% (5.3 + 3.0 + 2.7 + 4.6 = 15.6%) received four or fewer services; compared to Latinos of which 21.8% (7.6 + 4.8 + 4.0 + 5.4 = 21.8%) received four or fewer services; and compared to all other ethnic groups of which 32.6% (13.2 + 6.2 + 7.2 + 6.0 = 32.6%) received four or fewer services.

Figure 52 also shows that among API consumers served, 32.6% received 5 to 15 services and 51.7% received 16 or more services; compared to Latinos of which 32.5% received 5 to 15 services, and 45.6% received 16 or more services; and compared to all other ethnic groups of which 35.0% received 5 to 15 services, and 32.4% received 16 or more services.

FIGURE 53: RETENTION RATE IN OUTPATIENT SHORT DOYLE/MEDI-CAL FACILITIES BY AGE GROUP
FY 2011 - 2012 - SA 8



Retention Rate = Number of Approved Outpatient Claims

Figure 53 shows that among Child consumers served in Outpatient Short Doyle/Medi-Cal facilities in SA 8, 16.0% (5.9 + 4.0 + 3.2 + 2.9 = 16.0%) received four or fewer services; compared to Older Adults of which 29.7% (6.4 + 4.6 + 6.2 + 12.5 = 29.7%) received four or fewer services; and all other age groups of which 28.4% (9.1 + 5.8 + 4.7 + 8.8 = 28.4%) received four or fewer services.

Figure 53 also shows that among Children served, 27.5% received 5 to 15 services and 56.6% received 16 or more, compared to Older Adults of which 41.5% received 5 to 15 services, and 28.8% received 16 or more services; and all other age groups of which 36.7% received 5 to 15 services, and 35.0% received 16 or more services.

SECTION 3

QI WORK PLAN EVALUATION REPORT FOR CY 2012

LACDMH provides a full array of treatment services as required under W&IC Sections 5600.3, State Medi-Cal Oversight Review Protocols. The QI Work Plan Goals are in place to continuously improve the quality of the service delivery system. In accordance with State standards, the LACDMH evaluation of Quality Improvement activities are structured and organized according to the following:

1. Monitoring Service Delivery Capacity
2. Monitoring Accessibility of Services
3. Monitoring Beneficiary Satisfaction
4. Monitoring Clinical Care
5. Monitoring Continuity of Care
6. Monitoring Provider Appeals

The QI Work Plan Goals for 2012 define specific QI goals that pertain to key QI monitoring functions. These specific goals focus on monitoring access to services for target populations, timeliness of services, language needs of consumers, consumer satisfaction with services, quality of services, and other goals as identified by the LACDMH.

Consistent with the Federal Block Grant, which includes National Outcomes Measures (NOMs) and State Performance Contract, the LACDMH selects performance indicators for their relevance, feasibility, scientific validity, and meaningful value in improving the lives of consumers, families, and stakeholders of mental health services. A uniform set of performance indicators are utilized to ensure accountability and effectiveness of the quality and quantity of community and hospital based services. The selected measures are also consistent with national and standardized empirically-derived performance indicators (NOMs) from the 16-State Study (Lutterman, et al. 2003) and recommendations from the National Association of State Mental Health Program Directors Research Institute (NASMHPD).

The following QI Work Plan Evaluation Report section provides an evaluation summary on the progress made by LACDMH in reaching each stipulated goal.

QUALITY IMPROVEMENT WORK PLAN CY 2012

I. MONITORING SERVICE DELIVERY CAPACITY

1. a. The Penetration Rate for Latinos living at below the 200% Federal Poverty Level (FPL) will be maintained at 44.2% (CDHCS Rates) or 38.2% (CHIS Rates).

b. The Penetration Rate for Asian/Pacific Islanders below the 200% Federal Poverty Level (FPL) will be maintained at 27.6% (CDHCS Rates) or 23.9% (CHIS Rates).

c. The Retention Rate for Latinos will be maintained at 32.0% for 5-15 services and at 38.8% for 16 or more services.

d. The Retention Rate for Asian/Pacific Islanders (API) will be maintained at 35.7% for 5-15 services and at 41.3% for 16 or more services.

2. Identify an underserved population in a specific service area and pilot an intervention(s) to increase penetration rates for that population.

II. MONITORING ACCESSIBILITY OF SERVICES

1. Maintain access to after-hours care at 70% of PMRT response time of one hour between PMRT acknowledgements of the call to PMRT arrival on the scene and continue year to year trending.

2. Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) at an overall annual rate of 15%.

3. Increase the overall rate by 1% from 87.7% in 2011 to 88.7% in 2012 for consumers/families reporting that they are able to receive services at convenient locations and continue year to year trending. [Source: Performance Outcomes].

4. Increase the overall rate by 1% from 89.7% in 2011 to 90.7% in 2012 for consumer/families reporting that they are able to receive services at convenient times and continue year to year trending. [Source: Performance Outcomes].

III. MONITORING BENEFICIARY SATISFACTION

1. Administer the County Performance Outcomes Survey for two weeks in February in collaboration with the Integrated Substance Abuse Program (ISAP) of UCLA to evaluate and improve survey sampling methodology, and continue year to year trending.

2. Increase by 1% from 89.0% in 2011 to 90.0% in 2012 consumers/families reporting that staff were sensitive to cultural/ethnic background [Source: Performance Outcomes].

3. Increase by 1% from 84.4% in 2011 to 85.4% in 2012 the Overall Satisfaction Percentage Score and initiate year to year trending. [Source: Performance Outcomes]

4. Continue to identify areas for improvement for Service Area QICs for use in quality improvement activities, and increase Service Area Quality Improvement Projects from 2 to 4.

5. Continue to monitor and improve beneficiary grievances, appeals and State Fair Hearings processes, including instituting new electronic system and annual reporting for policy changes.

6. Continue to improve responsiveness to Beneficiary Requests for Change of Provider. Continue to monitor reports on the reasons given by consumers for their change of provider request and integrate measures into the new electronic system.

IV. MONITORING CLINICAL CARE

1. Continue to improve medication practices through systematic use of medication protocols and trainings for the use of medication forms and clinical documentation for existing staff and for new staff.

2. Initiate a Care Integration Collaborative Performance Improvement Project (PIP) to ensure that each consumer receives services that are integrated to address co-occurring disorders (mental health, physical health, and substance abuse).

V. MONITORING CONTINUITY OF CARE

1. Consumers will receive continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital (Post Hospitalization Outpatient Access – PHOA) and continue RC2 PIP in collaboration with APS/EQRO and Statewide consultants. LACDMH Managed Care Division will implement a new intervention to reduce Inpatient Readmission Rates by having staff conduct site visits to hospitals in order to improve continuity of care as well as reporting discharge data to hospitals and outpatient service providers.

VI. MONITORING OF PROVIDER APPEALS

1. Continue monitoring the rate of zero appeals through CY 2012.

I. MONITORING SERVICE DELIVERY CAPACITY

Goal I.1.

a. ***The Penetration Rate for Latinos living at or below the 200% Federal Poverty Level (FPL) will be maintained at 44.2% (CDHCS Rates) or 38.2% (CHIS Rates).***

b. ***The Penetration Rate for Asian/Pacific Islanders living at or below the 200% Federal Poverty Level (FPL) will be maintained at 27.6% (CDHCS Rates) or 23.9% (CHIS Rates).***

c. ***The Retention Rate for Latinos will be maintained at 32.0% for 5-15 services and at 38.8% for 16 or more services.***

d. ***The Retention Rate for Asian/Pacific Islanders (API) will be maintained at 35.7% for 5-15 services and at 41.3% for 16 or more services.***

Penetration Rate Numerator: Unduplicated number of consumers served by ethnicity during the fiscal year.

Penetration Rate Denominator: Total County population living at or below 200% FPL estimated with SED and SMI.

Retention Rate Numerator: Number of consumers receiving 5-15 and 16 or more approved outpatient claims.

Retention Rate Denominator: Total number of consumers receiving approved outpatient claims.

EVALUATION

In the current QI Work Plan Evaluation Report, prevalence rates utilized to estimate SED and SMI were derived from the California Health Interview Survey (CHIS) and are being incorporated into the current disparity analysis. This analysis includes comparisons with estimated rates provided by CHIS and the State DHCS.

The CHIS rates are estimated from a random sample of surveys on the population of the County of Los Angeles. Previous Work Plan Evaluation Reports used prevalence rates from estimates provided by the California Department of Mental Health (CDMH). CDMH estimated rates, currently provided by the California Department of Health Care Services (CDHCS), are derived from regression estimates using nationwide and statewide trends. The CHIS prevalence rates are expected to be more precise in calculating estimated SED and SMI for the County of Los Angeles.

TABLE 24A: FOUR YEAR TREND IN PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FPL BASED ON PREVALENCE RATE FROM CDHCS AND CHIS

Penetration Rate Based on CDHCS

Ethnicity	FY 08-09	FY 09-10	FY 10-11	FY 11-12
African American	115.9%	147.3%	156.1%	147.1%
Consumers Served	43,508	45,102	47,859	45,474
Estimated population with SED/SMI	37,534	30,613	30,655	30,911
Asian/Pacific Islander	22.9%	27.2%	27.6%	24.3%
Consumers Served	8,239	8,455	8,591	8,702
Estimated population with SED/SMI	35,994	31,109	31,152	35,781
Latino	33.1%	41.0%	44.2%	42.5%
Consumers Served	78,697	83,498	90,127	93,251
Estimated population with SED/SMI	237,864	203,790	204,068	219,435
Native American	102.1%	121.9%	119.7%	203.6%
Consumers Served	937	940	924	948
Estimated population with SED/SMI	918	771	772	466
White	62.6%	78.2%	81.3%	69.4%
Consumers Served	36,625	37,083	38,607	36,119
Estimated population with SED/SMI	58,530	47,425	47,490	52,075
Total	45.3%	55.8%	59.2%	54.5%
Consumers Served	168,006	175,078	186,870	184,494
Estimated population with SED/SMI	370,840	313,709	314,136	338,668

Penetration Rate Based on CHIS

Ethnicity	FY 08-09	FY 09-10	FY 10-11	FY 11-12
African American	100.4%	127.6%	135.2%	127.4%
Consumers Served	43,508	45,102	47,859	45,474
Estimated population with SED/SMI	43,343	35,351	35,399	35,694
Asian/Pacific Islander	19.8%	23.5%	23.9%	21.1%
Consumers Served	8,239	8,455	8,591	8,702
Estimated population with SED/SMI	41,565	35,924	35,973	41,318
Latino	28.7%	35.5%	38.2%	36.8%
Consumers Served	78,697	83,498	90,127	93,251
Estimated population with SED/SMI	274,676	235,329	235,650	253,396
Native American	88.4%	105.6%	103.6%	176.3%
Consumers Served	937	940	924	948
Estimated population with SED/SMI	1,060	890	892	538
White	54.2%	67.7%	70.4%	60.1%
Consumers Served	36,625	37,083	38,607	36,119
Estimated population with SED/SMI	67,588	54,764	54,839	60,135
Total	39.2%	48.3%	51.3%	47.2%
Consumers Served	168,006	175,078	194,339	184,494
Estimated population with SED/SMI	428,232	362,259	362,753	391,081

Data Source: LACDMH –IS for Consumers, U.S. Census Bureau, California Department of Finance for poverty estimates, CDHCS and CHIS for Prevalence Rates. Estimated prevalence rate of SED and SMI for population living at or below 200% FPL is 8.04% for CDHCS and 9.7&% for CHIS. The CDHCS prevalence rates by ethnicity: African American 6.1%, API 3.6%, Latino 5.9%, Native American 6.9%, and White 5.3%. The CHIS prevalence rates with Confidence Intervals (CI) by ethnicity: African American 26.4% [CI 7.6-45.3], API 4.7% [CI 2.2-10.1], Latino 7.6% [CI 6.0-10.4], Native American 9.2% [CI 0.0-27.0], and White 9.2% [CI 5.8-13.6].

Table 24A shows the four year trend in penetration rates using prevalence estimates from CDHCS and CHIS. The table shows that for all ethnic groups, the penetration rates are higher with prevalence rates from CDHCS as compared with CHIS.

In 2012 the QI Division calculated prevalence rates for population living at or below 200% FPL and total population using data from CHIS and CDHCS. The CHIS collects survey data on mental health utilization patterns from the population of the County of Los Angeles every two years within each Service Area and by the ethnicity. This allows for more precise estimates of prevalence and provides the ability to conduct trend analysis. Prevalence rates from CDHCS are based on a national sample and are estimated at the County level. Therefore applying CDHCS estimates to the population at the Service Area level skews the rates, especially for geographic areas with disproportionate distribution by ethnicity and age group.

TABLE 24B: PENETRATION RATE BY ETHNICITY AND SERVICE AREA BASED ON PREVALENCE RATES FROM CHIS FY 2011 - 2012

Ethnicity and Service Area	Number of Consumers Served[1]	Total Population Estimated with SED and SMI	Penetration Rates for Total Population[2]	Population Living At or Below 200% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living At or Below 200% Federal Poverty Level[2]
SA 1					
African American	3,502	4,435	79.0%	3,392	103.2%
Asian/Pacific Islander	103	1,099	9.4%	291	35.4%
Latino	3,162	12,541	25.2%	8,867	35.7%
Native American	65	116	56.0%	48	135.4%
White	2,902	10,026	28.9%	2,953	98.3%
Total	9,734	28,217	34.5%	15,551	62.6%
SA 2					
African American	3,059	5,506	55.6%	2,647	115.6%
Asian/Pacific Islander	1,042	17,517	5.9%	4,934	21.1%
Latino	14,705	61,267	24.0%	44,890	32.8%
Native American	117	284	41.2%	77	151.9%
White	9,730	71,397	13.6%	21,898	44.4%
Total	28,653	155,971	18.4%	74,446	38.5%
SA 3					
African American	3,405	4,780	71.2%	2,277	149.5%
Asian/Pacific Islander	2,124	35,858	5.9%	15,581	13.6%
Latino	16,180	59,019	27.4%	35,115	46.1%
Native American	114	219	52.1%	62	183.9%
White	4,469	28,030	15.9%	7,171	62.3%
Total	26,292	127,906	20.6%	60,206	43.7%

TABLE 24B: PENETRATION RATE BY ETHNICITY AND SERVICE AREA BASED ON PREVALENCE RATES FROM CHIS FY 2011 - 2012

Ethnicity and Service Area	Number of Consumers Served[1]	Total Population Estimated with SED and SMI	Penetration Rates for Total Population[2]	Population Living At or Below 200% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living At or Below 200% Federal Poverty Level[2]
SA 4					
African American	10,678	4,448	240.1%	2,595	411.5%
Asian/Pacific Islander	2,648	9,338	28.4%	7,708	34.4%
Latino	21,867	40,270	54.3%	37,035	59.0%
Native American	285	164	173.8%	90	316.7%
White	7,481	16,084	46.5%	8,328	89.8%
Total	42,959	70,304	61.1%	55,756	77.0%
SA 5					
African American	2,228	2,715	82.1%	960	232.1%
Asian/Pacific Islander	247	6,214	4.0%	2,401	10.3%
Latino	2,678	7,336	36.5%	4,164	64.3%
Native American	46	70	65.7%	9	511.1%
White	3,799	30,175	12.6%	7,346	51.7%
Total	8,998	46,510	19.3%	14,880	60.5%
SA 6					
African American	16,228	20,934	77.5%	14,105	115.1%
Asian/Pacific Islander	238	1,339	17.8%	1,045	22.8%
Latino	13,519	49,350	27.4%	45,145	29.9%
Native American	51	106	48.1%	88	58.0%
White	1,161	1,796	64.6%	1,050	110.6%
Total	31,197	73,525	42.4%	61,433	50.8%
SA 7					
African American	1,882	2,808	67.0%	1,376	136.8%
Asian/Pacific Islander	535	8,536	6.3%	2,567	20.8%
Latino	16,178	69,458	23.3%	44,037	36.7%
Native American	282	198	142.4%	68	414.7%
White	2,844	13,768	20.7%	3,883	73.2%
Total	21,721	94,768	22.9%	51,931	41.8%
SA 8					
African American	10,384	16,594	62.6%	8,343	124.5%
Asian/Pacific Islander	2,284	17,489	13.1%	6,791	33.6%
Latino	13,886	44,197	31.4%	34,142	40.7%
Native American	121	261	46.4%	96	126.0%
White	6,941	33,030	21.0%	7,507	92.5%
Total	33,616	111,571	30.1%	56,879	59.1%

TABLE 24B: PENETRATION RATE BY ETHNICITY AND SERVICE AREA
BASED ON PREVALENCE RATES FROM CHIS
FY 2011 - 2012

Ethnicity and Service Area	Number of Consumers Served[1]	Total Population Estimated with SED and SMI	Penetration Rates for Total Population[2]	Population Living At or Below 200% Federal Poverty Level and Estimated with SED and SMI	Penetration Rates for Population Living At or Below 200% Federal Poverty Level[2]
Unduplicated Consumers Served in At Least 1 Service Area					
African American	45,474	56,822	80.0%	35,694	127.4%
Asian/Pacific Islander	8,702	91,373	9.5%	41,318	21.1%
Latino	93,251	296,789	31.4%	253,396	36.8%
Native American	948	1,110	85.4%	538	176.3%
White	36,119	142,530	25.3%	60,135	60.1%
Total	184,494	588,624	31.3%	391,081	47.2%
Duplicated Consumers Served in One or More Service Areas					
		Percent*			
African American	5,892	12.9%			
Asian/Pacific Islander	519	6.6%			
Latino	8,924	9.6%			
Native American	133	14.0%			
White	3,208	8.8%			
Total	18,676	10.1%			

Data Source: California Health Interview Survey (CHIS)
Notes:
[1] Numbers Served represent consumers served by LACDMH in Short Doyle/Medi-Cal Facilities. This count does not include consumers served by Fee-For Service Outpatient Providers, Institutional facilities such as jails and probation camps as well as Inpatient Fee-For Service and County Hospitals.
[2] Penetration Rate = Number of Consumers Served / Number of People Estimated with SED & SMI.
* Duplicated consumers by ethnicity/unduplicated consumers by ethnicity (For example, 5,892/45,474 = 12.9% for African American.)

Table 24B shows the Penetration Rates for SED and SMI Population by Ethnicity and Service Area using CHIS Prevalence Rates. The Penetration Rates for Population living at or below 200% Federal Poverty Level are lower for API's and Latinos Countywide and across all Service Areas in comparison to other ethnic populations.

Disparities by Service Area

Disparities are defined using demographic data specific to each Service Area. Strategies are matched where unmet needs are estimated to exist using Penetration Rates by Service Area for Estimated SED and SMI Populations Enrolled in Medi-Cal using CHIS prevalence rates.

The following are specific populations with estimated unmet needs by Service Area:

SA 1: API, Latinos and Older Adults.

SA 2: API, Latinos, White, Children, Older Adults, Men and Women.

SA 3: API, Latinos, Children, Older Adults, Men and Women.

SA 4: API and Older Adults.

SA 5: API and Older Adults.

SA 6: API, Latinos, Children, TAY, Older Adults and Women.

SA 7: API, Latinos, Children, Older Adults, Men and Women.

SA 8: API, Latinos, Children, and Older Adults.

By Ethnicity:

API's are estimated to be underserved in all Service Areas, and Latinos are estimated to be underserved in all Service Areas except Service Areas 4 and 5.

By Age Group:

Older Adults are estimated to be underserved in all Service Areas. Children are estimated to be underserved in Service Areas 2, 3, 6, 7, and 8. TAY are estimated to be underserved in Service Area 6.

By Gender:

Men and women are underserved in Services Areas 2, 6 and 7. Women are underserved in Service Area 6.

TABLE 25: RETENTION RATE BY ETHNICITY – NUMBER OF CONSUMERS WITH APPROVED OUTPATIENT CLAIMS - FY 2011 - 2012

Number of Claims	African American	Asian/Pacific Islander	Latino	Native American	Other	White	Total
One							
Consumers	3,953	623	7,782	51	98	3,320	15,827
Percent	8.7%	7.2%	8.3%	5.4%	8.6%	9.2%	8.5%
Two							
Consumers	2,772	351	4,875	49	70	2,322	10,439
Percent	6.1%	4.0%	5.2%	5.2%	6.1%	6.4%	5.6%
Three							
Consumers	2,348	313	3,982	43	50	1,805	8,541
Percent	5.2%	3.6%	4.3%	4.5%	4.4%	5.0%	4.6%
Four							
Consumers	2,595	324	3,968	41	60	2,002	8,990
Percent	5.7%	3.7%	4.3%	4.3%	5.3%	5.5%	4.8%
5-15							
Consumers	15,777	2,829	28,301	318	377	12,422	60,024
Percent	34.7%	32.5%	30.3%	33.5%	33.0%	34.4%	32.3%
16 or More							
Consumers	17,714	4,217	43,663	440	479	14,013	80,526
Percent	39.0%	48.5%	46.8%	46.4%	42.0%	38.8%	43.4%
Total							
Consumers	45,474	8,702	93,251	948	1,141	36,119	185,635
Percent	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Data Source: LACDMH – IS Database, October 2012.
Note: 1,288 (1.0%) of 185,635 not included [185,635-1,288 = 184,347].

Table 25 shows the Retention Rate Countywide: The highest percentage with 5 to 15 approved outpatient claims was for African Americans at 34.7%, followed by Whites at 34.4%, Native Americans at 33.5%, “Other” at 33.0%, Asian/Pacific Islanders at 32.5% and Latinos at 30.3%.

Countywide, the highest percentage with 16 or more approved outpatient claims was for Asian/Pacific Islanders at 48.5%, followed by Latinos at 46.8%, Native Americans at 46.4%, “Other” at 42.0%, African Americans at 39.0% and Whites at 38.8%.

TABLE 26: RETENTION RATE - NUMBER OF APPROVED OUTPATIENT CLAIMS - FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012

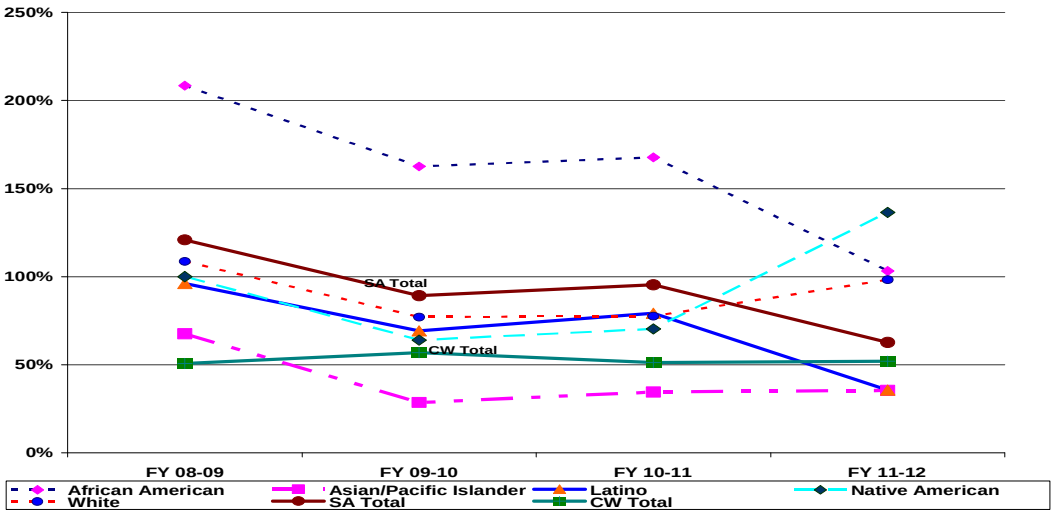
Number of Claims	Fiscal Year			
	FY 08-09	FY 09-10	FY 10-11	FY 11-12
1 Claim				
Consumers	17,296	17,400	22,196	15,827
Percent	10.7%	10.3%	12.6%	8.6%
2 Claims				
Consumers	9,222	9,604	12,953	10,439
Percent	5.7%	5.7%	7.4%	5.7%
3 Claims				
Consumers	7,444	8,058	10,404	8,541
Percent	4.6%	4.8%	5.9%	4.6%
4 Claims				
Consumers	6,471	7,056	9,303	8,990
Percent	4.0%	4.2%	5.3%	4.9%
5-15 Claims				
Consumers	47,872	52,166	58,549	60,024
Percent	29.7%	30.9%	33.2%	32.6%
16 + Claims				
Consumers	72,901	74,491	62,941	80,526
Percent	45.2%	44.1%	35.7%	43.7%
Total				
Consumers	161,206	168,775	176,346	184,347
Percent	100.0%	100.0%	100.0%	100.0%

Data Source: LACDMH – IS Database, October 2012.

Table 26 shows the four-year trend for Retention Rate. Between FY 08-09 and FY 11-12 the percentage of consumers receiving only one service or claim decreased by 2.1% from 10.7% in FY 08-09 to 8.6% in FY 11-12. There was no change in percentage of consumers receiving 2 or 3 services or claims during the four fiscal years.

The percentage of consumers receiving 5-15 services or claims increased by 2.9% from 29.7% in FY 08-09 to 32.6% in FY 11-12. The percentage of consumers receiving 16 or more claims decreased by 1.5% from 45.2% in FY 08-09 to 43.7% in FY 10-11.

FIGURE 54: PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL – FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012 - SA 1



Data Source: IS Tables for consumers and CHIS Prevalence Rates.

Figure 54 shows the 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 08-09 to FY 11-12 in Service Area 1.

FIGURE 55: RETENTION RATE BY ETHNICITY FY 2011 - 2012 - SA 1

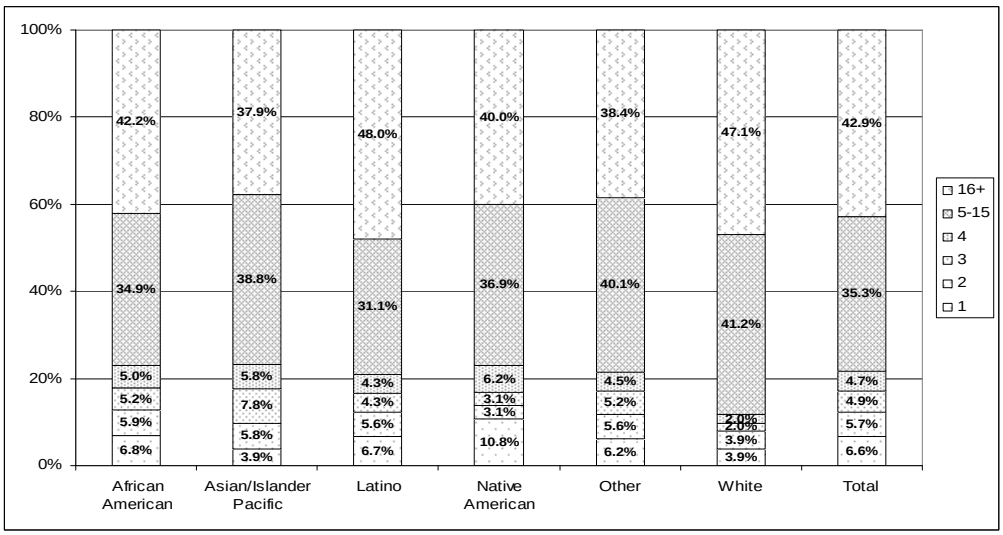
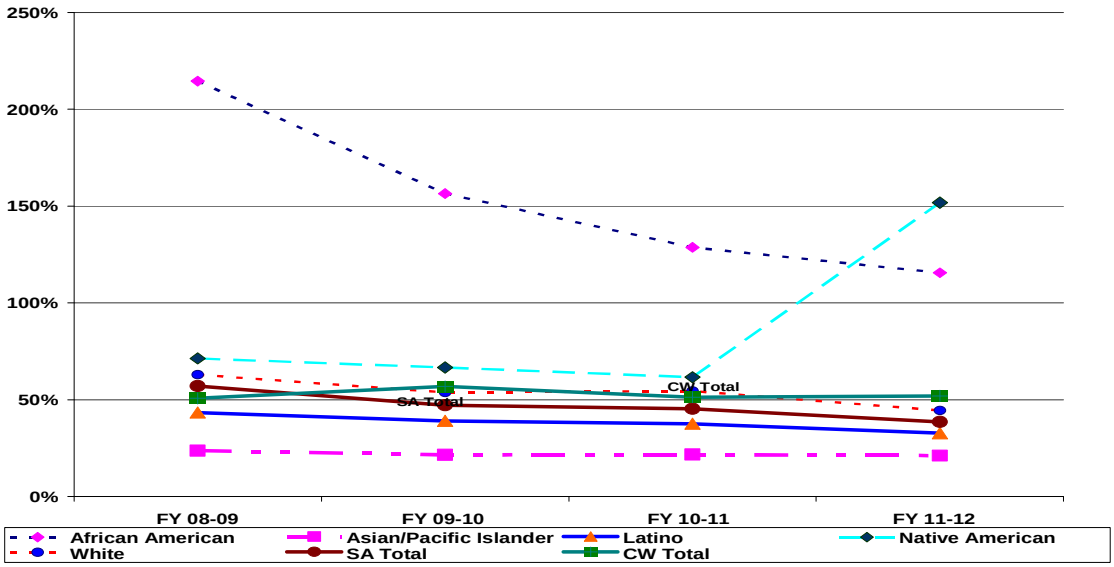


Figure 55 shows the Number of Approved Outpatient Claims (Retention Rate) by ethnicity for consumers served in FY 11-12 in Service Area 1.

FIGURE 56: PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL – FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012- SA 2



Data Source: IS Tables for consumers and CHIS Prevalence Rates.

Figure 56 shows the 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 08-09 to FY 11-12 in Service Area 2.

FIGURE 57: RETENTION RATE BY ETHNICITY FY 2011 - 2012 - SA 2

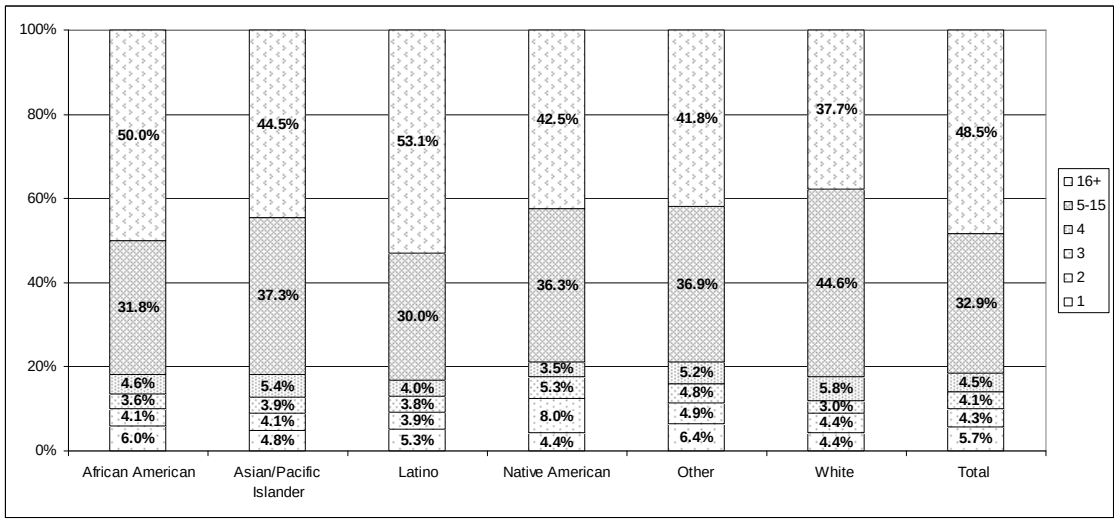
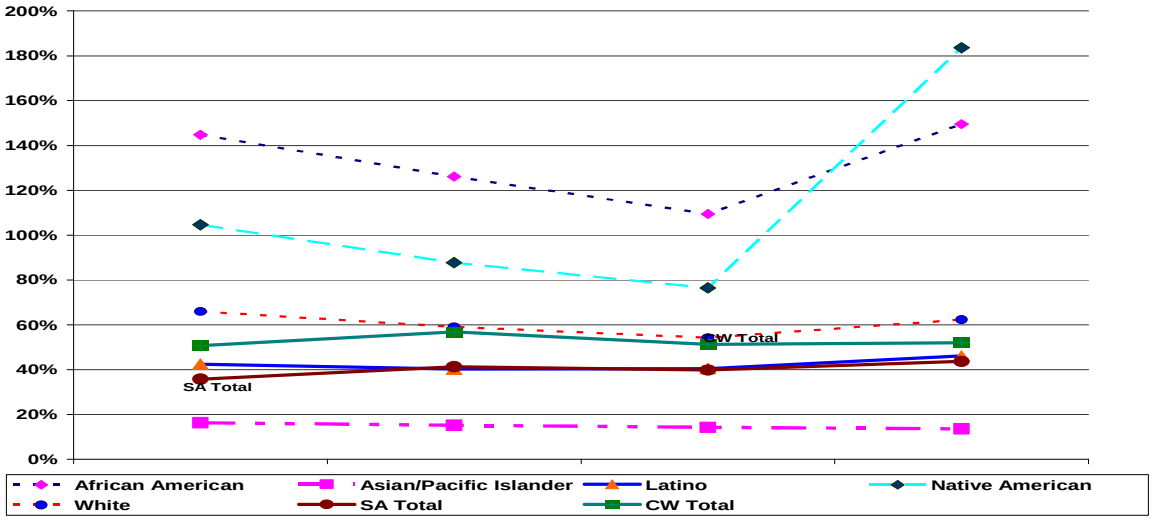


Figure 57 shows the Number of Approved Outpatient Claims (Retention Rate) by ethnicity for consumers served in FY 11-12 in Service Area 2.

FIGURE 58: PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL – FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012- SA 3



Data Source: IS Tables for consumers and CHIS Prevalence Rates.

Figure 58 shows the 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 08-09 to FY 11-12 in Service Area 3.

FIGURE 59: RETENTION RATE BY ETHNICITY FY 2011 - 2012 - SA 3

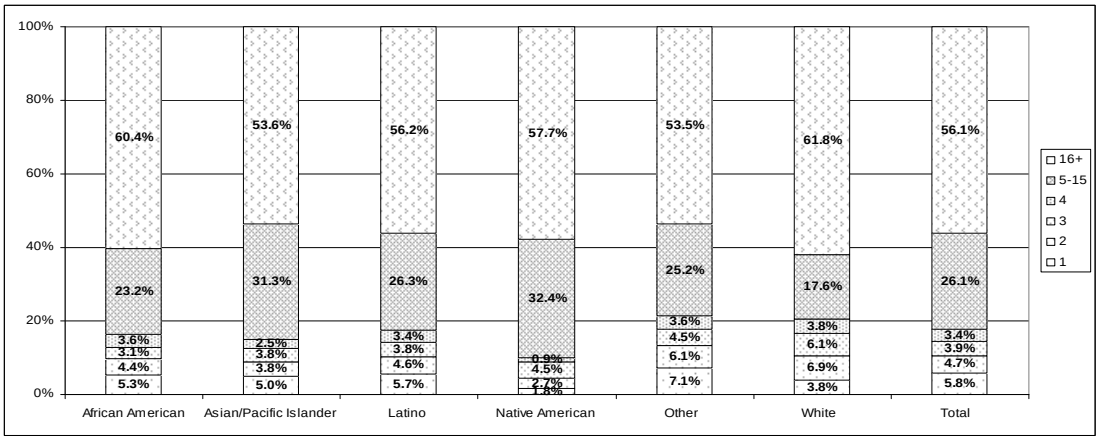
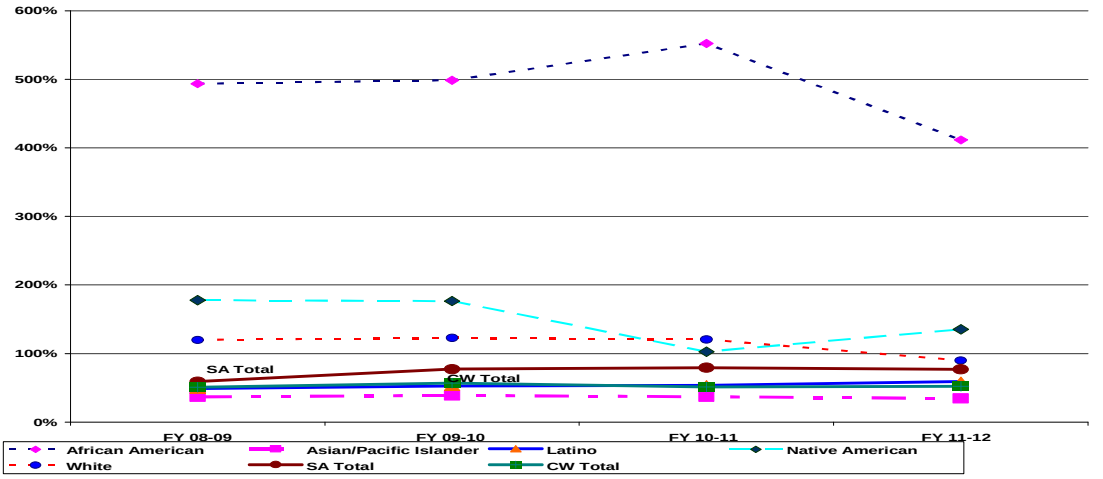


Figure 59 shows the Number of Approved Outpatient Claims (Retention Rate) by ethnicity for consumers served in FY 11-12 in Service Area 3.

FIGURE 60: PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL – FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012 - SA 4



Data Source: IS Tables for consumers and CHIS Prevalence Rates.

Figure 60 shows the 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 08-09 to FY 11-12 in Service Area 4.

FIGURE 61: RETENTION RATE BY NUMBER OF APPROVED OUTPATIENT CLAIMS FY 2011 - 2012 - SA 4

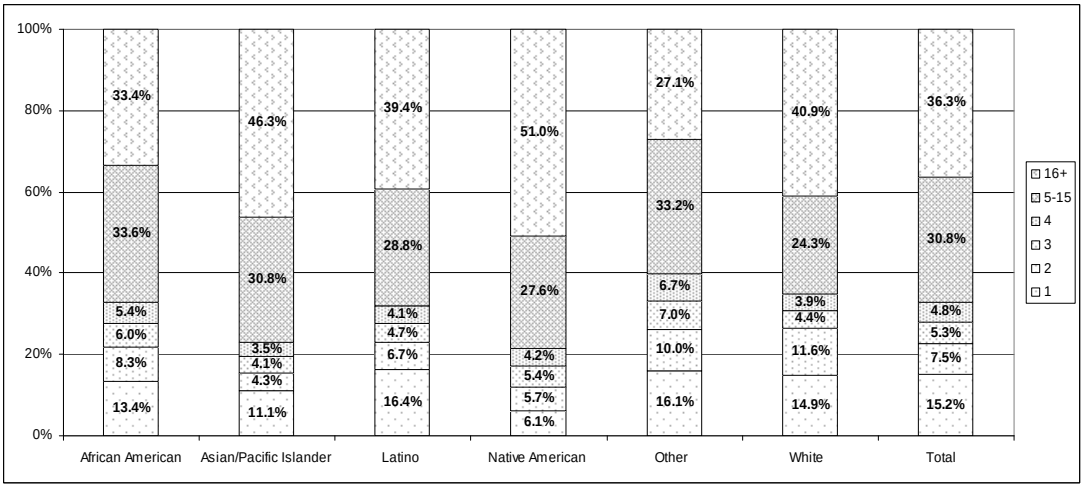
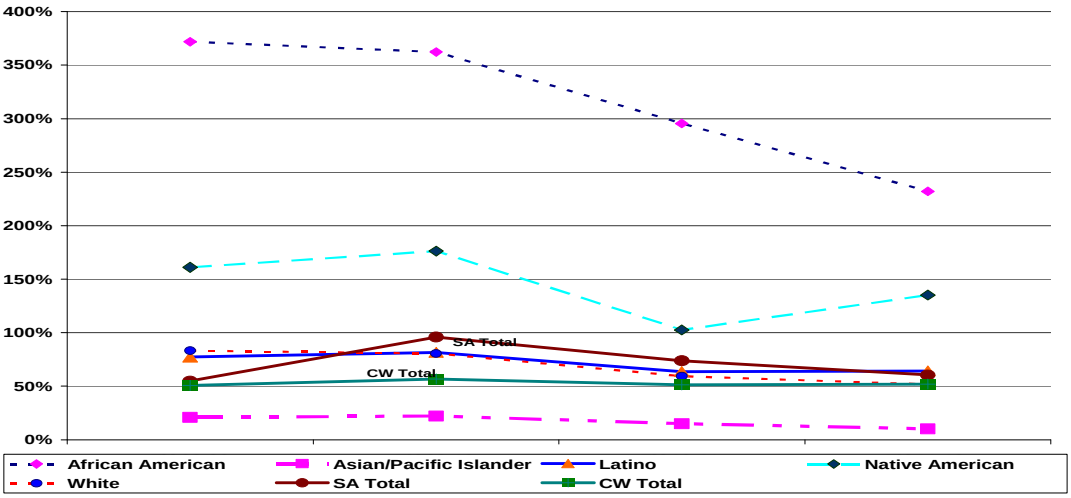


Figure 61 shows the Number of Approved Outpatient Claims (Retention Rate) by ethnicity for consumers served in FY 11-12 in Service Area 4.

FIGURE 62: PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL – FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012 - SA 5



Data Source: IS Tables for consumers and CHIS Prevalence Rates.

Figure 62 shows the 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 08-09 to FY 11-12 in Service Area 5.

FIGURE 63: RETENTION RATE BY ETHNICITY FY 2011 - 2012 - SA 5

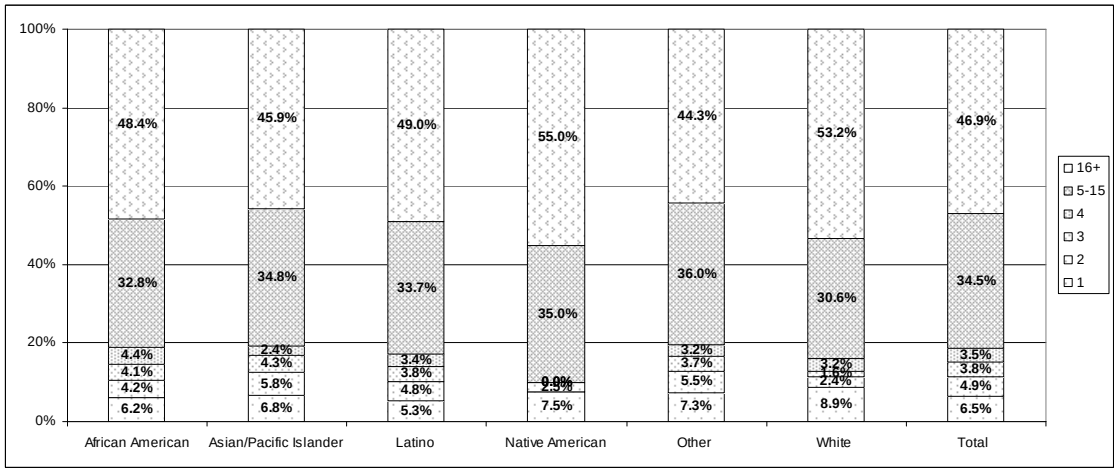
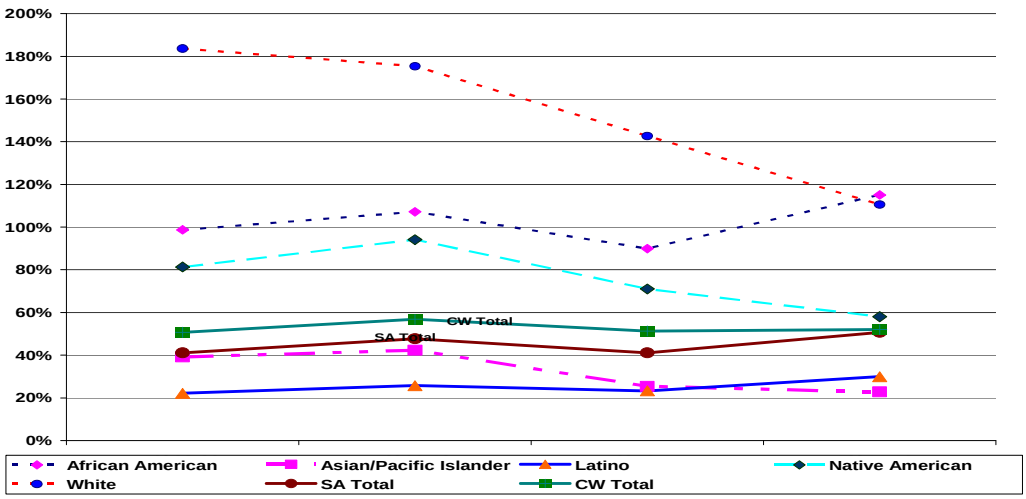


Figure 63 shows the Number of Approved Outpatient Claims (Retention Rate) by ethnicity for consumers served in FY 11-12 in Service Area 5.

FIGURE 64: PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL – FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012 - SA 6



Data Source: IS Tables for consumers and CHIS Prevalence Rates.

Figure 64 shows the 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 08-09 to FY 11-12 in Service Area 6.

FIGURE 65: RETENTION RATE BY ETHNICITY FY 2011 - 2012 - SA 6

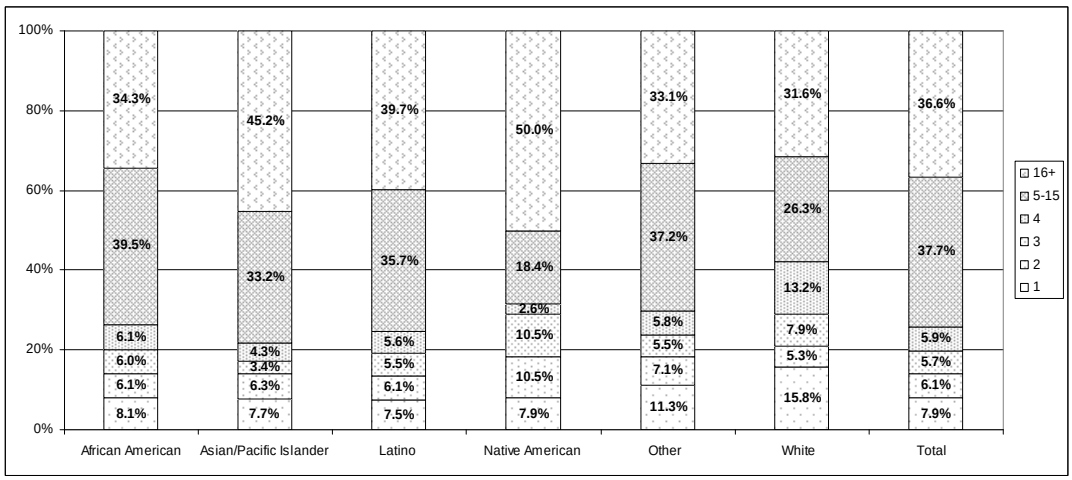
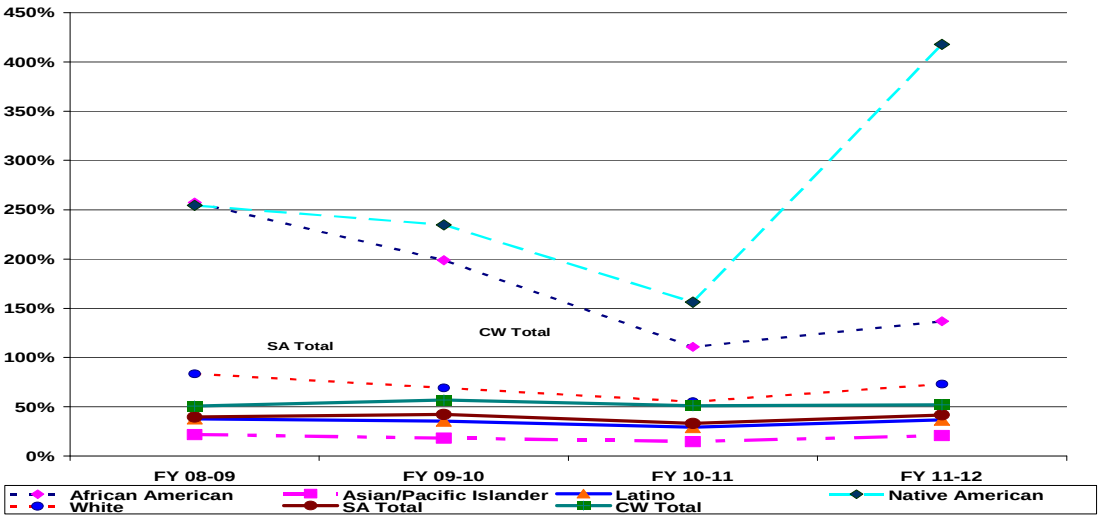


Figure 65 shows the Number of Approved Outpatient Claims (Retention Rate) by ethnicity for consumers served in FY 11-12 in Service Area 6.

FIGURE 66: PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL – FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012 - SA 7



Data Source: IS Tables for consumers and CHIS Prevalence Rates.

Figure 66 shows the 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 08-09 to FY 11-12 in Service Area 7.

FIGURE 67: RETENTION RATE BY ETHNICITY FY 2011 - 2012 - SA 7

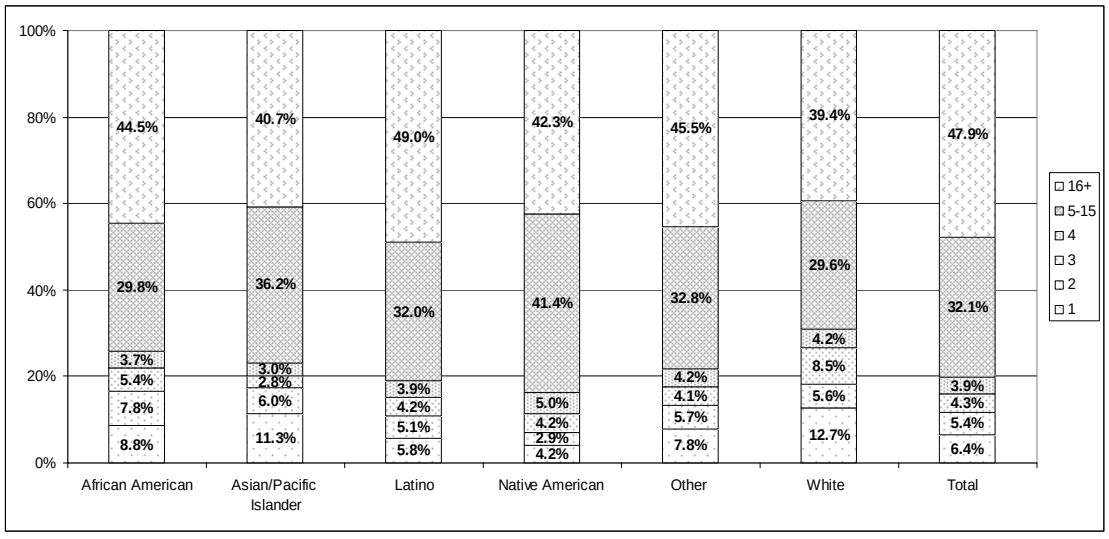
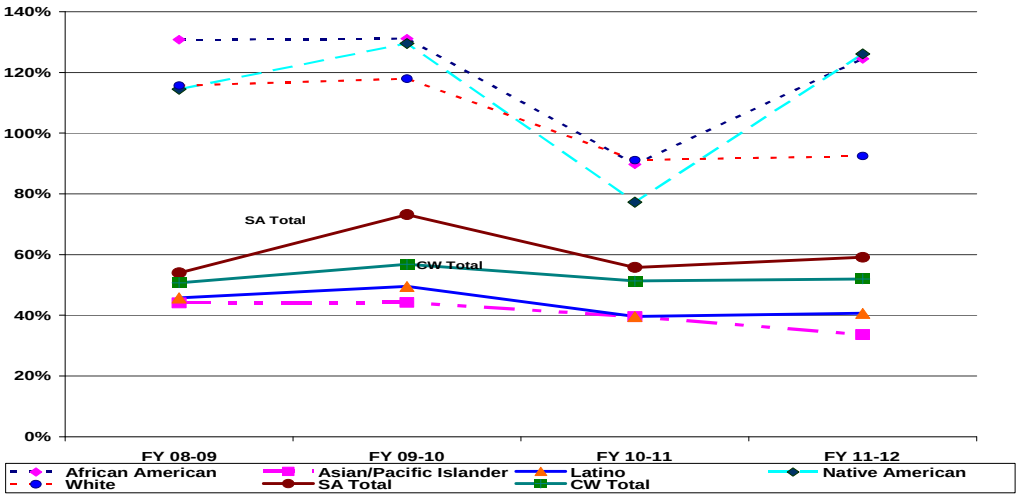


Figure 67 shows the Number of Approved Outpatient Claims (Retention Rate) by ethnicity for consumers served in FY 11-12 in Service Area 7.

FIGURE 68: PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL – FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012 - SA 8



Data Source: IS Tables for consumers and CHIS Prevalence Rates.

Figure 68 shows the 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 08-09 to FY 11-12 in Service Area 8.

FIGURE 69: RETENTION RATE BY ETHNICITY FY 2011 - 2012 - SA 8

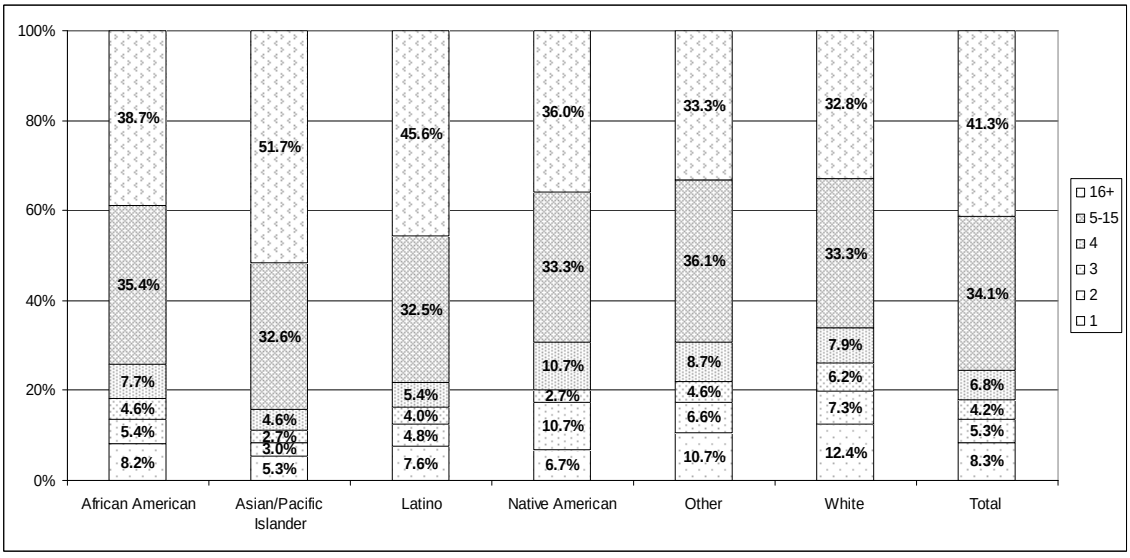
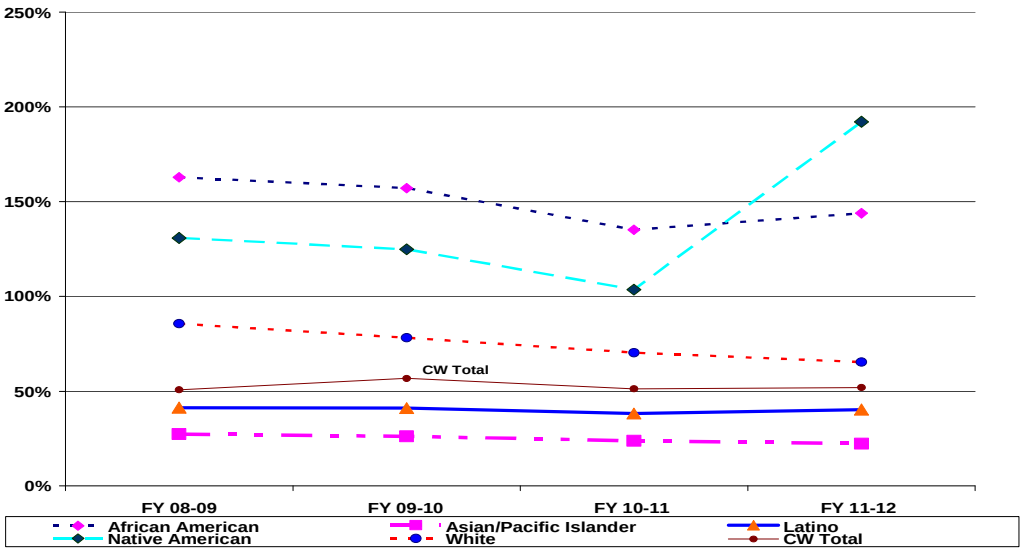


Figure 69 shows the Number of Approved Outpatient Claims (Retention Rate) by ethnicity for consumers served in FY 11-12 in Service Area 8.

FIGURE 70: PENETRATION RATE BY ETHNICITY FOR POPULATION LIVING AT OR BELOW 200% FEDERAL POVERTY LEVEL – FOUR YEAR TREND FY 2008 - 2009 TO FY 2011 - 2012 - COUNTYWIDE



Data Source: IS Tables for consumers and CHIS Prevalence Rates.

Figure 70 shows the Countywide 4-year trend for Penetration Rate for population living at or below 200% Federal Poverty Level from FY 08-09 to FY 11-12.

FIGURE 71: RETENTION RATE BY ETHNICITY FY 2011 - 2012 - COUNTYWIDE

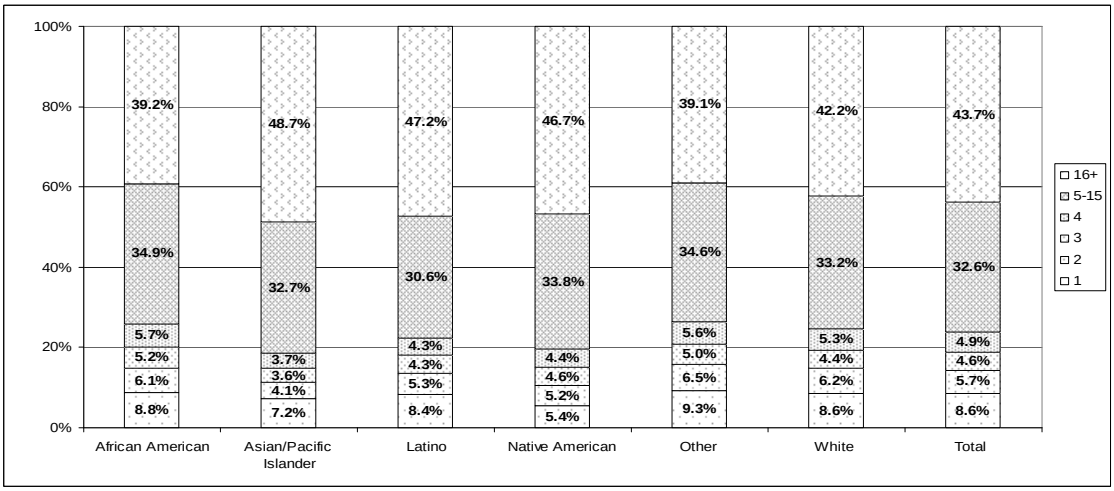


Figure 71 shows the Countywide Number of Approved Outpatient Claims (Retention Rate) by ethnicity for consumers served in FY 11-12.

Goal I.2.
Identify an underserved population in a specific service area and pilot an intervention(s) to increase penetration rates for that population.

In FY 11-12, LACDMH launched a Promotores de Salud (Health Promoters) Pilot Project in Service Areas 4 and 6 to increase access to mental health services for the Latino population. Promotores de Salud are well known in the health field as community-based change agents. Their success as health educators and health promoters has been attributed to the fact that they often belong to the neighborhood they serve; speak the language of their community; understand their community needs and available resources; and possess experience working with community members and organizations.

Three agencies were awarded contracts to implement this Project: Hathaway Sycamores Child and Family Services, Latino Behavioral Health Institute, and Special Service for Groups (SSG). Each agency recruited six (6) Promotores de Salud. A total of eighteen (18) unique Promotores de Salud were trained in mental health to serve as bridges that connect the Latino community to LACDMH via 1) strategic outreach targeting the Spanish-monolingual Latino population, especially the indigent; 2) culturally appropriate mental health education; 3) referrals to mental health services including Full Service Partnership (FSP) Programs, and other human service agencies; and 4) development and implementation of Spanish self-help groups for Latino individuals suitable for this level of intervention.

The Promotores de Salud Pilot Project consisted of two (2) phases: The mental health training of Promotores phase initiated on July 1, 2011 and lasted a period of twelve (12) consecutive weeks. The training content included: Common mental health disorders, substance abuse, domestic violence, culture specific syndromes, early signs of decompensation, high risk behaviors, stigma, suicidality, Wellness Recovery Action Plan (WRAP), navigation of the LACDMH system, FSP services, and culturally sensitive outreach, linkage and engagement. The mental health training phase was followed by one (1) full year fieldwork placement. During the fieldwork phase, the Promotores de Salud received supervision of their outreach, engagement, linkage and self-help group activities in SA 4 and 6. The Promotores de Salud Project concluded on December 30, 2012. The Project continues to gather data and will measure penetration outcomes during the first half of 2013. Data will be reported in the 2013 QI Work Plan Evaluation Report.

II. MONITORING ACCESSIBILITY OF SERVICES

Goal II.1.
Maintain access to after-hour care at 70% of PMRT response time of one hour between PMRT acknowledgement of the call to PMRT arrival on the scene and continue year to year trending.

Numerator: The number of after-hour PMRT responses arriving in one hour or less.

Denominator: Total number of after-hour PMRT responses.

EVALUATION

This goal has been partially met.

TABLE 27: PSYCHIATRIC MOBILE RESPONSE TEAM (PMRT) AFTER-HOUR RESPONSE RATES OF ONE HOUR OR LESS CY 2008 - 2012

Month	2008	2009	2010	2011	2012
January	78%	68%	67%	76%	69%
February	75%	69%	65%	72%	64%
March	74%	64%	63%	71%	66%
April	76%	68%	65%	69%	61%
May	71%	72%	63%	74%	66%
June	71%	72%	68%	68%	65%
July	71%	72%	71%	71%	70%
August	73%	62%	75%	67%	70%
September	72%	63%	74%	68%	65%
October	71%	69%	71%	68%	67%
November	70%	66%	70%	66%	70%
December	72%	66%	71%	68%	N/A
Annual Total	**3,357**	**3,448**	**3,857**	**4,288**	**3,984**
Annual Average %	**73%**	**68%**	**69%**	**70%**	**67%**

Note: December data is not available due to transition to the new phone monitoring system on November 27, 2012.

Table 27 shows that in 2012 (December data unavailable) an average of 67% of PMRT calls resulted in mobile teams being present at the scene within one hour or less from acknowledgement of receipt of the call. This reflects a 3% decrease over the previous year performance of 70%.

Trending analysis during a five (5) year period, from 2008 to 2012, show a consistent increase in the annual total number of after-hour PMRT responses to calls in one hour or less. The total number of after-hour PMRT responses to calls in one hour or less in 2008 was 3,357, in 2009 3,448, in 2010 3,857, in 2011 4,288, and in 2012 3,984 (December data unavailable).

Although higher response rates were achieved during 2008, at that time there were nine (9) psychiatric mobile response teams providing coverage as compared to five (5) teams beginning in 2009. The 5% drop in after-hour PMRT response time occurring in 2009 as compared to 2008 is also largely due to the reduced availability of after-hour PMRT capacity. Between 2009 and 2011 there has been a 1% improvement each year. This improvement occurred during an increase of 840 or 25% more calls from 3,448 in 2009 to 4,288 in 2011. In 2012 the response rate was 67% (December data unavailable).

The ACCESS Center implemented a new web-based telephone system on November 27th, 2012. This new technology may provide aggregate data that varies from the data submitted in prior reporting periods. CIOB and the ACCESS Center staff are evaluating the ability of the new system to provide comparable data.

The LACDMH utilizes the ACCESS Center PMRT responsiveness as an indicator of timeliness of field visits requiring rapid intervention and assistance. The rationale for this indicator concerns providing alternatives to hospitalization and linkage with other appropriate levels of care such as Urgent Care Centers. Additionally, the response time to urgent field visits is measured in four incremental response time categories, beginning with 45 minutes or less and ending with 91 minutes or more. The Performance Counts! Report provides detailed data for this indicator.

The PMRT measure reported is specific to responses made after-hours. It is important to emphasize that the Performance Counts! Measure uses the Fiscal Year time period, whereas the PMRT measure reported here uses a Calendar Year time period. The response time for all calls (N = 27,062) within one hour was 75% in FY 2011-2012.

ACCESS Center Abandoned Call Rate

Goal II.2.
Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) at an overall annual rate of 15%.

Numerator: Total number of calls in which caller hung up after 30 seconds.

Denominator: Total number of calls completed to the ACCESS Center.

EVALUATION

This goal has not been met.

LACDMH's ACCESS Center provides emergency and non-emergency services. The ACCESS Center strives to meet the cultural and linguistic needs of our communities by providing language assistance services in threshold and non-threshold languages at the time of first contact. Callers request information related to mental health services and other social needs, and the ACCESS Center supplies them with referrals to culture-specific providers and services that are appropriate to their needs and conveniently located.

The ACCESS Center Abandoned Call Rate is used as an indicator of response time to calls received by the 24/7 Toll-Free Telephone Line for mental health services and other referrals as appropriate, including the calls received in non-English languages. It is also a means of measuring linguistic and cultural accessibility to mental health services. This national indicator is also monitored by LACDMH Test-Calls Protocols and data is reported in the Annual Test-Calls Report prepared by the Quality Improvement Division. (See Appendix for Test-Calls Report 2012).

TABLE 28: ABANDONED CALLS BY NUMBER AND PERCENT
CY 2012

Month	Total Calls	Number Abandoned	Percent Abandoned
January	27,808	3,688	13%
February	27,817	4,244	15%
March	29,088	4,829	17%
April	26,717	4,211	16%
May	31,975	7,129	22%
June	25,252	4,309	17%
July	26,869	4,285	16%
August	30,688	6,638	22%
September	27,388	5,212	19%
October	32,458	6,458	20%
November	23,318	3,798	16%
December	N/A	N/A	N/A
Total	**253,602**	**54,801**	**21.6%**

Note: Data for 2012 is reported for 11 months from January to November. The ACCESS Center implemented a new web-based telephone system on November 27th, 2012. This new technology may provide aggregate data that varies from the data submitted in prior reporting periods. CIOB and the ACCESS Center staff are evaluating the ability of the new system to provide comparable data. Data on Abandoned Calls for December 2012 will be reported in the QI Evaluation Report, 2013.

Table 28 shows an average abandoned call rate of 21.6% during the months of January through November 2012. The average number of calls per month from January to November was 28,125.

The ACCESS Center is currently upgrading and improving its phone system which is expected to yield further improvement in the effective and timely processing of calls. A vendor has been selected and initiated the contracted work on November 27, 2012.

TABLE 29: ABANDONED CALL RATE FIVE YEAR TREND
CY 2008 - 2012

Calendar Year	2008	2009	2010	2011	2012*
Total Calls	275,051	283,098	295,016	304,470	253,602
Number Abandoned	35,401	40,107	44,499	46,149	54,801
Percent	13%	14%	15%	15%	21.6%

*Data for 2012 is reported for 11 months from January to November. The ACCESS Center implemented a new web-based telephone system on November 27, 2012. This new technology may provide aggregate data that varies from the data submitted in prior reporting periods. CIOB and the ACCESS Center staff are evaluating the ability of the new system to provide comparable data. Data on Abandoned Call Rate for December 2012 will be reported in the QI Evaluation Report, 2013.

ACCESS Center Calls Received in Non-English Languages

Non-English Speaking and Limited English Proficiency persons have a right to receive services in their primary or preferred language. LACDMH has 13 threshold language including: Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese. When ACCESS Center staff cannot assist callers because of a language barrier, they immediately contact the Language Line for assistance with language interpretation services. The ACCESS Center also provides equitable language assistance services to deaf/hearing impaired consumers and providers requesting American Sign Language (ASL) interpretation services for their consumers.

TABLE 30: NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER FOUR YEAR TREND - CY 2009 - 2012

Language	2009	2010	2011	2012
AMHARIC	4	0	2	2
*ARABIC	5	13	7	4
*ARMENIAN	34	36	35	61
BENGALI	0	3	1	2
BULGARIAN	0	1	0	0
BURMESE	1	3	0	0
*CAMBODIAN	6	5	0	23
*CANTONESE	48	19	19	7
*FARSI	21	31	46	59
FRENCH	0	1	2	1
GERMAN	0	2	0	0
HEBREW	1	0	0	0
HINDI	5	0	1	5
HUNGARIAN	0	0	0	0
ITALIAN	1	1	0	0
JAPANESE	6	7	6	5
KHMER	0	5	16	12
*KOREAN	79	61	54	83
LAOTIAN	0	0	0	0
*MANDARIN	39	59	52	40
OROMO	2	0	0	0
POLISH	3	0	0	0
PORTUGUESE	1	1	0	0
PUNJABI	4	2	0	0
SERBIAN	0	5	0	0
ROMANIAN	0	1	0	1
*RUSSIAN	8	15	21	26
SERBIAN	0	5	0	0
*SPANISH	4,940	4,547	4,282	4,552
SPANISH ACCESS CTR	4,055	4,644	4,393	4,043
SPANISH SUB TOTAL	8,995	9,191	8,675	8,595
*TAGALOG	35	26	35	14
THAI	0	6	2	1
TURKISH	2	0	0	1
URDU	1	1	1	3
*VIETNAMESE	31	23	15	23
TOTAL	9,332	9,523	8,990	8,968

*LACDMH Threshold Language excluding Other Chinese and English. Note: Data for 2012 is reported for 11 months from January to November. The ACCESS Center implemented a new web-based telephone system on November 27, 2012. Data on language calls for December 2012 will be reported in the QI Evaluation Report, 2013.

Table 30 summarizes the total number of calls in 34 non-English languages received by the ACCESS Center for calendar years 2009 through 2012. The trending over the last four years indicates that the majority of non-English callers requested language interpretation services in the threshold languages, and mostly in Spanish. Additionally noted were calls received in Korean, Mandarin, Cantonese, Armenian, Farsi, Tagalog, and Russian.

In 2012 the ACCESS Center received 8,595 calls in Spanish or 95.8% of all non-English calls. Spanish is the most common language after English for calls received by the ACCESS Center in 2012. The second most common language of non-English calls received by the ACCESS Center in 2012 was Korean at 83 calls or 1.0% of all non-English calls.

Consumer Satisfaction Survey Goals

Goal II.3.
Increase the overall rate by 1% from 87.7% in CY 2010 to 88.7% in CY 2012 for consumers/families reporting that they are able to receive services at convenient locations and continue year-to-year trending.

EVALUATION

This goal has been partially met.

TABLE 31: CONSUMERS/FAMILIES STRONGLY AGREE OR AGREE WITH "LOCATION OF SERVICES WAS CONVENIENT FOR ME" BY AGE GROUP[1]

AGE GROUP	FY 07-08 May-08	FY 08-09 Nov-08	FY 08-09 May-09	FY 11-12 Feb-12
YSS-F				
Number	7,648	8,463	6,889	9,920
Percent	91.8%	92.3%	93.3%	93.7%
YSS				
Number	5,282	5,684	4,577	5,974
Percent	80.6%	81.3%	82.9%	81.0%
Adult				
Number	6,327	6,644	5,559	9,855
Percent	82.8%	83.9%	84.6%	84.7%
Older Adult				
Number	363	593	615	1,211
Percent	87.1%	88.1%	90.0%	82.4%
Total				
Number	19,620	21,384	17,640	26,960
Percent	85.6%	86.4%	87.7%	87.1%

*YSS-F = survey for guardians of children 0-12 years old; YSS = survey for youth 12 to 17 years

[1] Per CDMH Memo June 14, 2010, Consumer Satisfaction Survey data collection was suspended for CY 2010.

Table 31 shows percent of consumers and families that agree or strongly agree they received services at convenient locations for four (4) distinct survey periods, from May 2008 to February 2012. For YSS-F, the percent increased from 91.8% in May 2008 to 93.7% in February 2012. For YSS, the percent increased from 80.6% in May 2008 to 81.0% in February 2012. For Adult, the percent increased from 82.8% in May 2008 to 84.7% in February 2012. For Older Adult, the percent decreased from 87.1% in May 2008 to 82.4% in February 2012. Overall for all age groups, the percent increased from 85.6% to 87.1%.

Goal II.4.
Increase the overall rate by 1% from 89.7% in CY 2010 to 90.7% in CY 2012 for consumer/families reporting that they are able to receive services at convenient times and continue year to year trending.

EVALUATION

This goal has not been met.

TABLE 32: PERCENT STRONGLY AGREE OR AGREE WITH "SERVICES WERE AVAILABLE AT TIMES THAT WERE GOOD FOR ME" BY AGE GROUP[1]

AGE GROUP	FY 07-08 May-08	FY 08-09 Nov-08	FY 08-09 May-09	FY 11-12 Feb-12
YSS-F				
Number	7,648	8,463	6,889	9,920
Percent	93.0%	93.7%	94.1%	94.2%
YSS				
Number	5,282	5,684	4,577	5,974
Percent	79.7%	79.5%	81.7%	81.7%
Adult				
Number	6,327	6,644	5,559	9,855
Percent	90.5%	87.9%	89.7%	89.5%
Older Adult				
Number	363	593	615	1,211
Percent	90.8%	92.7%	93.4%	93.2%
Total				
Number	19,620	21,384	17,640	26,960
Percent	88.5%	88.5%	89.7%	89.7%

*YSS-F = survey for guardians of children 0-12 years old; YSS = survey for youth 12 to 17 years

[1] Per CDMH Memo June 14, 2010, Consumer Satisfaction Survey data collection was suspended for CY 2010.

Table 32 shows percent of consumers and families that agree or strongly agree that services were available at times that were convenient for them for four (4) distinct survey periods, from May 2008 to February 2012. For YSS-F, the percent increased from 93.0% in May 2008 to 94.2% in February 2012. For YSS the percent increased from 79.7% in May 2008 to 81.7% in February 2012. For Adult the percent decreased from 90.5% in May 2008 to 89.5% in February 2012. For Older Adult, the percent increased from 90.8% in May 2008 to 93.2% in February 2012. Overall, for all age groups the percent increased from 88.5% to 89.7%.

III. MONITORING BENEFICIARY SATISFACTION

Goal III.1.
Administer the County Performance Outcomes Survey for two weeks in February in collaboration with the Integrated Substance Abuse Program (ISAP) of UCLA to evaluate and improve survey sampling methodology, and continue year to year trending.

EVALUATION

This goal has been met.

For this survey period, LACDMH partnered with the UCLA Integrated Substance Abuse Programs (ISAP) to pilot an abbreviated version of the MHSIP surveys previously used to gather the County Outcome Measures. The goal of this initiative is to allow LACDMH to transition from the MHSIP State Performance Outcome Measures to a new and meaningful data collection methodology that ensures the following: 1) Randomized representative sampling; 2) Cost-effective user friendly abbreviated forms; 3) Trend analysis of satisfaction domains, and 4) Enhanced statistical analysis and scientific rigor for internal annual performance monitoring.

The County Performance Outcome Measures consists of 3 surveys, the Family Survey (0 to 17 years of age to be completed by the child's guardian), the Youth Survey (13 to 17 years of age) and the Adult Survey (18 years of age and above), each with 7 survey questions. A total of 10 items from the initial survey are used for the seven questions of the 3 abbreviated surveys that have been developed. These 10 items were adopted from the 64 item MHSIP surveys via an inter-disciplinary Stakeholder process carried out in 2007 (Note: Please refer to State Performance Outcomes and County Performance Outcomes Report CY 2008 for additional information). Initial data using these abbreviated surveys was first collected in 2008 in field settings and subsequent abbreviated survey collections have continued to occur.

The FY 11-12 Consumer Satisfaction Surveys data collection survey period took place from February 13, 2012, to February 27, 2012. All Directly Operated and Contracted Outpatient Mental Health Clinics, in addition to DMH Outpatient Fee-For-Service (FFS) Individual Providers, administered the Consumer Satisfaction Surveys.

The LACDMH has previously participated annually, each May and November, in the State Performance Outcome for consumer and family perception of satisfaction survey administration. In 2008, the LACDMH began collecting MHSIP survey data to provide a baseline performance standard that could be used to gage data obtained in future years. In 2009, follow up data was collected and comparative analysis with baseline standards was carried out. This data is

presented in the May 2009 State Performance Outcomes and County Performance Outcomes Report.

In 2010 the Mental Health Plan Directors of California were sent the following California Department of Mental Health memo dated June 14, 2010:

"In recognition of the economic pressures placed upon state and local governments, the May DMH consumer perception survey county data collection requirement will be suspended for this year to help relieve administrative burden on counties. However, in order to fulfill SAMHSA Block Grant requirements to collect this data, DMH will collaborate with the Institute for Social Research (ISR) in developing and pilot testing a random sampling approach for Fiscal year 2010-2011."

The State DMH implemented this MHSIP pilot in July 2010. In November 7, 2011, in DMH Information Notice No. 11-14, the State DMH informed the County Mental Health Plans that the California Institute for Mental Health (CiMH) had been contracted to scan and process survey forms as well as to aggregate data collected by the counties. Counties were asked to organize and implement their own Consumer Satisfaction Survey data collection, and submit their data to CiMH. LACDMH initiated the pilot survey in collaboration with the UCLA-ISAP in October 2011.

Over the past several years the Consumer Satisfaction Survey methodology has undergone the following changes: 1) Survey administration reduced from twice a year to once a year; 2) Survey administration reduced from a survey collection period of two weeks to one week; 3) Survey administration to Outpatient Day Treatment and Field Based Programs increased additionally to include Fee for Service (FFS); and 4) Additionally in February 2012 County Performance Outcome surveys were administered using the abbreviated MHSIP survey.

Description of County Performance Outcome Measures Derived from the Stakeholder Processes of 2007

Youth Surveys and Youth Surveys for Families: Of the seven (7) domains measured in the original MHSIP YSS-F and YSS Surveys, five domains (General Satisfaction, Perception of Access, Perception of Cultural Sensitivity, Perception of Outcomes of Services and Perception of Social Connectedness) are represented in the LACDMH Outcome Measures abbreviated survey.

The General Satisfaction domain is represented by one item: "I felt I/My child had someone to talk to when he/she was troubled." The Perception of Access domain consists of two items: "The location of services was convenient for me/us", and "Services were available at times that were convenient for me/us." Both of these items are represented in the abbreviated survey and are not tested for reliability. The Perception of Cultural Sensitivity is presented by one item:

"Staff were sensitive to my cultural/ethnic background." The Perception of Outcomes of Services is represented by two items: "My child/I get along better with family members" and "My child/I am doing better in school and/or work." The Perception of Social Connectedness is represented by one item: "In a crisis, I would have the support I need from family or friends."

The remaining two domains from the original survey, Perception of Participation in Treatment Planning and Perception of Functioning are not represented in the abbreviated survey.

Adult Surveys (for Adults and Older Adults): Of the seven (7) domains measured in the original MHSIP Adult and Older Adult Surveys, four domains (Perception of Access, Perception of Quality and Appropriateness, Perception of Outcomes of Services and Perception of Functioning) are represented in the LACDMH Outcome Measures abbreviated survey.

The Perception of Access domain is represented by three items: "The location of services was convenient", "Staff were willing to see me as often as I felt it was necessary", and "Services were available at times that were good for me." The Perception of Quality and Appropriateness is represented by one item: "Staff were sensitive to my cultural/ethnic background." The Perception of Outcomes of Services is represented by two items: "I deal more effectively with my daily problems" and "I do better in school and/or work". Perception of Functioning is represented by one item: "My symptoms are not bothering me as much".

The remaining three domains from the original survey, General Satisfaction, Perception of Participation in Treatment Planning and Perception of Social Connectedness are not represented in the abbreviated survey.

County Performance Outcome Survey Results

TABLE 33A: COUNTY PERFORMANCE OUTCOME SURVEY FINDINGS FOR ALL AGE GROUPS FEBRUARY 2012

Outcome Measure	Average Percent[1]	Rank Order
Services were available at times that were convenient [3]	89.7%	**1**
Staff was willing to see me as often as I felt was necessary [2]	88.8%	**2**
I felt my child/I had someone to talk when he/she/I was troubled [4]	87.4%	**3**
Location of services was convenient [3]	87.1%	**4**
Staff were sensitive to my cultural/ethnic background [3]	86.1%	**5**
In a crisis, I would have the support I need from family or friends [4]	84.8%	**6**
My child/I get along better with family members [4]	73.2%	**7**
I deal more effectively with daily problems [2]	72.4%	**8**
Doing better in school and/or work [3]	63.5%	**9**
My symptoms are not bothering me as much [2]	60.7%	**10**

[1] Percent "Strongly Agree" or "Agree"

[2] Outcomes for Adults & Older Adults only

[3] Outcomes for YSS-F, YSS, Adult & Older Adult

Table 33A shows that the satisfaction ratings on the County Performance Outcome Survey items (either “agree” or “strongly agree” with each item statement) range from 60.7% to 89.7%. The item ranking highest is “Services were available at convenient times” (89.7%), the item ranking lowest is “My symptoms are not bothering me as much” (60.7%). Satisfaction ratings for items indicating clinical improvement through treatment (e.g. level of symptomology, improvement in work and/or school, ability to deal with daily problems, interpersonal relationships with family and friends, and availability of friends or family in crisis) range from 60.7% to 84.8%. Satisfaction ratings for items related to service delivery to consumers (e.g. sensitivity to cultural background, convenience of locations, availability of staff in times of emotional need, scheduling of services) range from 86.1% to 89.7%.

TABLE 33B: YSS AND YSS-F SURVEY HIGHEST AND LOWEST PERCENT RATINGS BY SERVICE AREA

Outcome Measure		YSS-F (N = 9,920)	Among Service Areas		YSS (N = 5,976)	Among Service Areas	
			Highest	Lowest		Highest	Lowest
1	I felt my child/I had someone to talk to when he/she/I was troubled.	90.1%	SA 5 (92.3%)	SA 7 (87.1%)	**82.9%**	SA 7 (85.6%)	SA 2 (81.0%)
2	Location of services was convenient for us/me.	93.7%	SA 7 (94.6%)	SA 1 (92.1%)	81.0%	SA 3 (86.1%)	SA 4 (76.5%)
3	Services were available at times that were convenient for us/me.	**94.2%**	SA 8 (96.1%)	SA 1 (91.6%)	81.7%	SA 7 (86.5%)	SA 4 (77.3%)
4	Staff were sensitive to my cultural/ethnic background.	91.1%	SA 4 (93.4%)	SA 5 (89.1%)	76.8%	SA 7 (81.3%)	SA 5 (72.4%)
5	My child/I get along better with family members.	76.4%	SA 4 (81.2%)	SA 1 (69.5%)	**67.8%**	SA 6 (73.7%)	SA 1 (63.2%)
6	My child/I am doing better in school and/or work.	**71.7%**	SA 4 (77.6%)	SA 1 (65.2%)	73.0% *	SA 4 (75.7%)	SA 1 (68.4%)
7	In a crisis, I would have the support I need from family or friends.	86.8%	SA 7 (88.8%)	SA 2 (84.9%)	81.5% *	SA 6 (83.8%)	SA 2 (79.1%)

Highest and lowest percentages are in bold.
* Differences among service areas are not statistically significant at $p < .05$

Table 33B shows that for all Outcome Measure items of the Abbreviated YSS-F Survey there are significant differences in Satisfaction ratings (percentage of consumers indicating that they either "agree" or "strongly agree" with each item) among all Service Areas. Two (2) individual items exhibit differences greater than 10% between the highest and lowest Service Area ratings. The first is "My child gets along better with family members" with the highest rating in SA 4 at 81.2% and the lowest rating in SA 1 at 69.5% (a difference of 11.7%). The second is "My child is doing better in work and school" with the highest rating in SA 4 at 77.6% and the lowest rating in SA 1 at 65.2% (a difference of 12.4%). Other significant differences among the Service Areas range from 5.2% to 2.5%.

In addition, on the items of the Abbreviated YSS-F Survey, SA 4 scored highest on three (3) items, SA 7 scored highest on two (2) items, and SAs 5 and 8 scored highest on one (1) item. SA 1 scored lowest on four (4) items, and SAs 7, 5, and 2 scored lowest on one (1) item.

Table 33B also shows that for all but two (2) Abbreviated YSS items there are significant differences among the Service Areas. These two items are: "I am doing better in school and/or work" and "In a crisis, I would have the support I need from family or friends".

In addition, on the items of the Abbreviated YSS Survey, SA 7 scored highest on three (3) items, SA 6 scored highest on two (2) items, and SAs 3 and 4 scored highest on one (1) item. SA 1, 2 and 4 scored lowest on two (2) items, and SA 5 scored lowest on one (1) item.

TABLE 33C: ADULT AND OLDER ADULT SURVEY HIGHEST AND LOWEST PERCENT RATINGS BY SERVICE AREA

	Outcome Measure	Adult (N = 9,855)	Among Service Areas		Older Adult (N = 1,211)	Among Service Areas	
			Highest	Lowest		Highest	Lowest
1	The location of services was convenient (Parking, Public Transportation, Distance, etc.)	84.7%	SA 1 (89.4%)	SA 8 (80.4%)	82.4%	SA 7 (89.5%)	SA 1 (50.0%)
2	Staff were willing to see me as often as I felt was necessary.	88.5%	SA 2 (92.8%)	SA 5 (87.0%)	91.7% *	SA 5 (94.9%)	SA 1 (87.5%)
3	Services were available at times that were good for me.	**89.5%**	SA 1 (94.7%)	SA 5 (87.4%)	**93.2% ***	SA 7 (95.9%)	SA 1 (87.5%)
4	Staff were sensitive to my cultural background (race, religion, language, etc.)	86.0%	SA 1 (91.5%)	SA 5 (84.1%)	90.8%	SA 6 (96.9%)	SA 4 (86.3%)
5	I deal more effectively with daily problems.	71.8% *	SA 3 (73.3%)	SA 1 (70.0%)	76.6% *	SA 5 (79.7%)	SA 8 (70.6%)
6	I do better in school and/or work.	**52.3%**	SA 6 (54.8%)	SA 5 (48.8%)	**40.1% ***	SA 7 (44.4%)	SA 1 (31.3%)
7	My symptoms are not bothering me as much.	60.0%	SA 3 (64.4%)	SA 1 (53.8%)	66.4% *	SA 6 (75.5%)	SA 8 (59.6%)

Highest and lowest percentages are in bold.
* Differences among service areas are not statistically significant at $p < .05$

Table 33C shows that SA 1 scored highest on three (3) items, SA 3 scored highest on two (2) items, SAs 2 and 6 scored highest in one (1) item. SA 5 scored lowest on four (4) items, SA 1 scored lowest on two (2) items, and SA 8 scored lowest on one (1) item. In addition, for Older Adults, SA 7 scored highest on three (3) items, and SAs 5 and 6 scored lowest on two (2) items.

Goal III.2.
Increase by 1.0% from 89.0% in CY 2010 to 90.0% in CY 2012 consumers/families reporting that staff were sensitive to cultural/ethnic background.

EVALUATION

This goal has not been met.

TABLE 34: AVERAGE PERCENT STRONGLY AGREE OR AGREE WITH "STAFF WERE SENSITIVE TO MY CULTURAL BACKGROUND" BY AGE GROUP[1]

AGE GROUP	FY 07-08 May-08	FY 08-09 Nov-08	FY 08-09 May-09	FY 11-12 Feb-12
YSS-F				
Number	7,648	8,463	6,889	9,920
Percent	95.2%	94.9%	95.5%	91.1%
YSS				
Number	5,282	5,684	4,577	5,974
Percent	82.6%	83.2%	84.6%	76.8%
Adult				
Number	6,327	6,644	5,559	9,855
Percent	84.9%	85.5%	84.6%	86.0%
Older Adult				
Number	363	593	615	1,211
Percent	90.1%	90.9%	91.2%	90.8%
Total				
Number	19,620	21,384	17,640	26,960
Percent	88.2%	88.6%	89.0%	86.1%

*YSS-F = survey for guardians of children 0-12 years old; YSS = survey for youth 12 to 17 years

[1] Per CDMH Memo June 14, 2010, Consumer Satisfaction Survey data collection was suspended for CY 2010.

Table 34 shows percent of consumers and families that agree or strongly agree that staff were sensitive to their cultural background for four (4) distinct survey periods, from May 2008 to February 2012. For YSS-F, the percent decreased from 95.2% in May 2008 to 91.1% in February 2012. For YSS the percent decreased from 82.6% in May 2008 to 76.8% in February 2012. For Adult the percent increased from 84.9% in May 2008 to 86.0% in February 2012. For Older Adult, the percent increased from 90.1% in May 2008 to 90.8% in February 2012. Overall, for all age groups the percent decreased from 88.2% to 86.1%.

Goal III.3.
Increase by 1% from 84.4% in CY 2010 to 85.4% in CY 2012 the Overall Satisfaction Percentage Score and initiate year to year trending.

EVALUATION

During February 2012, the County Performance Outcome surveys (abbreviated MHSIP) did not include survey items for the overall satisfaction domain. The full MHSIP State Performance Outcome surveys administered in August 2012 do include the overall satisfaction domain. Year to year trending will be reported next year.

Goal III.4.
Continue to identify areas for improvement for Service Area QICs for use in quality improvement activities, and increase Service Area Improvement Projects from 2 to 4.

EVALUATION

This goal has been partially met.

Three Service Areas have taken the initiative to develop projects within their Service Areas. The three Service Areas are SAs 4, 7, and 8.

Service Area 4: The Service Area 4 administration has initiated a project on improving client flow and filling slots for mental health services among providers serving consumers in the Service Area. A website has been developed that allows providers to enter the number of available slots for services at their agency. Other providers are able to view this information and refer consumers to appropriate services based on their availability. The availability of information includes language capacity at each provider location. This is expected to improve culturally competent services while appropriately utilizing available resources. This information will be refreshed in real-time and providers will have the most updated information for referring clients. A reporting system has been developed that will allow administrators to track daily reports on the availability and filling of available services in the Service Area. A mapping service and a link to public transportation has been added to the website that will allow providers to assess the geographic feasibility of referring clients to a provider location that is most convenient for them based on the location's accessibility via public transportation.

Service Area 7: From April 6 to May 19, 2011, SA 7 conducted a survey to investigate the client flow in the system of care in SA 7 LACDMH directly operated and contracted mental health clinics. Twenty six surveys were completed by representatives of four (4) directly operated programs and twenty-two (22) contracted agencies. Survey results reveal that all programs work to

provide an initial screening immediately so that appropriate referral and service can be provided. Surveyed agencies report varied timeliness goals. All programs report ongoing reassessment of consumers' level of care, varying from weekly to annual reassessment. Agencies report working to ensure clients are referred for higher or lower levels of care as and when appropriate. Most agencies (70.8% or 17 of 26 surveyed) report that the SA 7 Navigation Team has assisted with access to appropriate levels of care. SA 7 generated a report outlining the results of their survey and plan on conducting follow-up analysis as well as initiating a second phase of the project.

Service Area 8: Service Area 8 Quality Improvement Committee (QIC) members piloted a consumer driven project to increase access to information for consumers in SA 8. The goal is to provide information to consumers via informational kiosks to be located within mental health service location lobbies.

An Informational kiosk was placed at the Long Beach Mental Health Center Adult Clinic in Long Beach (LBMH). Information used for the kiosk project includes handouts listing local food banks, free clothing outlets, as well as agencies offering shelter and mental health services presented in a simple pocket guide format. The display board was titled "iCenter" per the suggestion of a consumer committee member. A poem written by Mrs. Virginia Howlett and entitled, "Welcome" was posted on the display board and best captures the purpose of the kiosk from a consumer perspective. The board also displayed "May Is Mental Health Month" events such as the LBMH Wellness Center's 11th Annual Celebration and Open House, the SA 8 monthly consumer community activity coordinated by Project Return, and the local Service Area Advisory Committee meeting flyer.

Members decided to implement the kiosk for one week from April 30 - May 4, 2012. Members agreed to use a one-item measure of success to monitor use and success of the kiosk item: Count the number of items remaining at the end of the week to ascertain the number taken. This measure was selected to minimize the staff time needed to count and monitor use of the items. All 300 copies of the community clothing and food resource list and 200 copies of the pocket guide were utilized during the kiosk period.

After the kiosk was piloted at LBMH, the committee made a decision to conclude the project and summarize the findings due to the lack of resources to continue the pilot at another site. Members discussed the next steps for the project and possible other events/settings that would benefit from a kiosk for TAY, Children, and schools. Future ideas for kiosks include displaying information such as parenting programs, referrals specific to the needs of the TAY population, and targeting school district staff with mental health information, and playing Metta World Peace's video in schools to promote mental health treatment.

Goal III.5.
Continue to monitor and improve beneficiary grievances, appeals and State Fair Hearings processes, including instituting new electronic system and annual reporting for policy changes.

EVALUATION

This goal has been met.

The Quality Improvement Division is responsible to conduct the "annual evaluation of beneficiary grievances, appeals, and fair hearings." (State Department of Health Care Services, Program Oversight and Compliance, 2012-2013)

The MHP shall insure that a procedure is included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the MHP's Quality Improvement Council, the MHP's administration or another appropriate body within the MHP. (State Department of Health Care Services, Program Oversight and Compliance, 2012-2013)

TABLE 35A: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FY 2010 - 2011 TO FY 2011 - 2012

CATEGORY	FY 10 - 11	FY 11 - 12
ACCESS	0	21
Percent	0.00%	100.00%
TERMINATION OF SERVICES	6	1
Percent	100.00%	100.00%
DENIED SERVICES (NOA - A Assessment)	6	0
Percent	100.00%	0.00%
CHANGE OF PROVIDER	3	10
Percent	100.00%	100.00%
QUALITY OF CARE		
Provider Relations	201	305
Percent	61.30%	57.10%
Medication	65	86
Percent	19.80%	16.10%
Discharge/Transfer	17	24
Percent	5.20%	4.50%
Patient's Rights Materials	3	12
Percent	0.90%	2.20%
Treatment Concerns	4	24
Percent	1.20%	4.50%
Abuse - Physical	13	32
Percent	4.00%	6.00%
Abuse - Sexual	3	8
Percent	0.90%	1.50%
Abuse Verbal	2	12
Percent	0.60%	2.20%
Abuse (Total)	18	52
Percent	5.50%	9.70%
Delayed Services	2	4
Percent	0.60%	0.70%
Seclusion and Restraint	5	11
Percent	1.50%	2.10%
Treatment Disagreement	10	N/A
Percent	3.00%	
Quality of Care	3	13
Percent	0.90%	2.40%
Reduction of Services	N/A	3
Percent		0.60%
Sub-Total for Quality of Care	**328**	**534**
Percent	100.00%	100.00%

TABLE 35A (Cont.): INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FY 2010 - 2011 TO FY 2011 - 2012

CATEGORY	FY 10 - 11	FY 11 - 12
CONFIDENTIALITY	9	10
	100.00%	100.00%
OTHER		
Access to Personal Belongings	5	1
Percent	10.40%	1.10%
Housing Concerns	5	17
Percent	10.40%	19.10%
Legal Concerns	3	11
Percent	6.30%	12.40%
Lost/Stolen Belongings	3	11
Percent	6.30%	12.40%
Money/Funding/Billing	8	10
Percent	16.70%	11.20%
Non HIPAA Concerns	1	2
Percent	2.10%	2.20%
Non Provider Concerns	10	3
Percent	20.80%	3.40%
Phone	4	6
Percent	8.30%	6.70%
Smoking	2	7
Percent	4.20%	7.90%
Visitors	1	1
Percent	2.10%	1.10%
Miscellaneous	6	13
Percent	12.50%	14.60%
Clothing	N/A	5
Percent		5.60%
Other	N/A	2
Percent		2.20%
Sub-Total for Other	**48**	**89**
Percent	100.00%	100.00%
Total	**400**	**665**
Percent	100.00%	100.00%

Note: Shaded cells without numerical values indicate that data is not available for the fiscal year.

Table 35A shows that the total number of inpatient and outpatient grievances and appeals increased by 67% from 400 in FY 10-11 to 665 in FY 11-12. The majority of inpatient and outpatient grievances and appeals were for Quality of Care for both FY 10-11 (82%) and FY 11-12 (80%). The increase in the volume of inpatient and outpatient grievances and appeals received during FY 11-12 may be partially attributed to increased monitoring and reporting by Service Area administration.

TABLE 35B: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS BY LEVEL AND DISPOSITION FY 2011 - 2012

CATEGORY	LEVEL				
	Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited State Fair Hearing
Access	21	0	0	0	0
Percent	3.0%	0.0%	0.0%	0.0%	0.0%
Termination of Services	1	1	0	0	0
Percent	0.0%	100.0%	0.0%	0.0%	0.0%
Denied Services (NOA- A Assessment)	0	0	0	0	0
Percent	0.0%	0.0%	0.0%	0.0%	0.0%
Change of Provider	10	0	0	0	0
Percent	2.0%	0.0%	0.0%	0.0%	0.0%
Quality of Care	534	0	0	0	0
Percent	80.0%	0.0%	0.0%	0.0%	0.0%
Confidentiality	10	0	0	0	0
Percent	2.0%	0.0%	0.0%	0.0%	0.0%
Other	89	0	0	0	0
Percent	13.0%	0.0%	0.0%	0.0%	0.0%
Total	665	1	0	0	0
Percent	100.0%	100.0%	0.0%	0.0%	0.0%

CATEGORY	DISPOSITION		
	Referred Out	Resolved	Still Pending
Access	0	21	0
Percent	0.0%	3.0%	0.0%
Termination of Services	0	1	0
Percent	0.0%	0.0%	0.0%
Denied Services (NOA- A Assessment)	0	0	0
Percent	0.0%	0.0%	0.0%
Change of Provider	0	10	0
Percent	0.0%	2.0%	0.0%
Quality of Care	16	518	0
Percent	59.0%	81.0%	0.0%
Confidentiality	8	2	0
Percent	30.0%	0.0%	0.0%
Other	3	86	0
Percent	11.0%	14.0%	0.0%
Total	27	638	0
Percent	100.0%	100.0%	0.0%

Table 35B shows that among the inpatient and outpatient grievances and appeals in FY 11-12 there were 665 Grievances and 1 Appeal. Table 35B also shows that by disposition among these Grievances and Appeals, 27 were Referred Out, 638 were Resolved, and none were reported as Still Pending.

At this time, the PRO is acquiring software to enhance data accuracy and processing capacity. It is expected that electronic reporting will enhance the ability to monitor and ensure Patient's Rights. The Quality Improvement Division will continue to meet its' commitment to monitor beneficiary grievances, appeals and State Fair Hearings as well as assist and support the PRO in developing increasingly sensitive and useful measures. (See QI Implementation Status Report for Annual Beneficiary Grievances and Appeals, dated March 2013)

Goal III.6.
Continue to improve responsiveness to Beneficiary Requests for Change of Provider. Continue to monitor reports on the reasons given by consumers for their change of provider request and integrate measures into the new electronic system.

EVALUATION

This goal has been met.

TABLE 36: REQUEST FOR CHANGE OF PROVIDER BY REASONS AND PERCENT APPROVED FY 2010 – 2011 TO FY 2011 - 2012

Reason*	FY 2010 - 2011			FY 2011 - 2012		
	Number of Requests	Percent Approved	Rank Order	Number of Requests	Percent Approved	Rank Order
Not A Good Match	200	83%	1	263	90.11%	1
Uncomfortable	172	89.9%	2	221	86.69%	2
Treatment Concerns	124	90.32%	3	154	89.61%	4
Other	118	89.83%	4	151	82.78%	5
Does Not Understand Me	104	78.85%	5	173	89.02%	3
Lack of Assistance	97	88.66%	6	134	88.06%	6
Insensitive/Unsympathetic	89	87.64%	7	125	88%	7
Medication Concerns	84	86.9%	8	107	92.52%	8
Gender	64	91.19%	9	83	87.95%	10
Not Professional	64	82.81%	10	99	88.89%	9
No Reason Given	57	80.7%	11	69	78.26%	11
Language	55	92.73%	12	54	92.59%	12
Time/Schedule	47	91.49%	13	48	91.67%	14
Want Previous Provider	29	86.21%	14	35	74.29%	15
Want 2nd Opinion	27	85.19%	15	49	85.71%	13
Age	19	78.95%	16	18	83.33%	16
Treating Family Member	5	100%	17	18	94.44%	16
Total	**1,355**			**1,801**		

*Sorted by Number of Requests in FY 10-11. Multiple Reasons may be given by a consumer.
Data Source: LACDMH Patients' Rights Office.

Table 36 shows the outpatient number of Request for Change of Provider by reasons, percent, and rank order according to frequency for FY 10-11 and FY 11-12. Data for the requests for change provider are based on the information from forms which agencies are required to submit on a monthly basis to the PRO. The total number of recorded Requests for Change of Provider increased by 33% from 1,355 in FY 10-11 to 1,801 in FY 11-12.

IV. MONITORING CLINICAL CARE

Goal IV.1.

Continue to improve medication practices through systematic use of medication protocols and trainings for the use of medication forms and clinical documentation for existing staff and for new staff.

EVALUATION

This goal has been met. (See QI Work Plan Implementation Status Report, Medication Support Services, October 2012.)

LACDMH continues to provide ongoing trainings and information to medical staff regarding best practices and LACDMH established parameters.

Over the past year, LACDMH has continued to develop policies related to LACDMH psychiatrists' roles and functions in activities related to HWLA, as well provide HWLA-related trainings for psychiatrists. Parameters for Psychiatric Consultation 2.10 was established May 21, 2012. This new parameter provides definitions for direct consultation, indirect consultation, and E-consultation, role specification and documentation considerations in response to the demands of new treatment models, including Integrated Care. The Office of the Medical Director hired a new Director of Pharmacy services, Dr. Russell Kim, and identified a Medical Director for Telemental Health, Dr. Ricardo Mendoza.

Dr. Carol Eisner Co-Chair of the QIC Council has a regular standing item for QIC monthly meetings. She reports on latest Medication Peer Review activities and improvements to medication monitoring protocols.

In 2012, a Medication Peer Review process evaluating practices involving patients who are being treated with 5 or more psychotropic medications was completed. In addition, a Medication Peer Review process evaluating practices involving patients who are being treated with 4 psychotropic medications was initiated.

Goal IV.2.

Initiate a Care Integration Collaborative Performance Improvement Project (PIP) to ensure that each consumer receives services that are integrated to address co-occurring disorders (mental health, physical health, and substance abuse).

The LACDMH, PSB, QID is participating with the California Institute of Mental Health (CiMH) to improve the quality and integration of care for persons with serious and co-occurring mental health, physical health, and/or substance use disorders. This CiMH pilot collaborative brings together five (5) participating counties: Los Angeles, Napa, Nevada, Orange and Riverside. The structure of this pilot collaborative is based on the Institute for Healthcare Improvement (IHI)

Breakthrough Series (BTS) Learning Collaborative Model. Over a twelve month period, county partnership teams will test and make changes to achieve better health status for the identified target population. The rapid cycle improvement strategies of Plan, Do, Study and Act (PDSA) will be implemented to address the challenges of integrated care, especially as related to the Medi-Cal 1115 Waiver. Additionally, this collaboration provides an opportunity to participate within the structure of a quality Performance Improvement Project (PIP) for clinical and non-clinical projects.

This Care Integration Collaborative is also known as the Integrated Mobile Health Teams (IMHT) project. The partners include: John Wesley Health Centers Institute, Inc. (JWCH), South Central Health and Rehabilitation Programs (SCHARP) and Behavioral Health Services (BHS). The Care Integration Collaborative Aim is to the improve the quality of life and health outcomes through IMHT coordinated care for identified homeless persons with Serious Mental Illness, substance abuse, and/or other chronic, complex physical health conditions. The key goals are to: Increase the number of clients who meet the screening criteria for Physical Health (PH), Mental Health (MH), and Substance Use Disorder (SUD) who are enrolled into the IMHT; increase the number of enrolled clients who are assigned to an IMHT with documented benefits establishment; increase the number of enrolled clients with housing; increase client-centered shared care plans for enrolled clients; and increase number of enrolled clients with documented measures for physical health, mental health, substance abuse, and quality of life.

The key change ideas for the project included:

1. The IMHT multidisciplinary team meetings changed from twice a week to daily with full team participation resulting in improved communication for coordinated and prioritized daily client assignments and follow up.
2. The IMHT screening process ensured higher enrollment and housing rates when the comprehensive screening tool was changed to focus on a smaller number of clients and a longer period of engagement.

V. MONITORING CONTINUITY OF CARE

Goal V.1.

Consumers receiving continuity of care by being seen within 7 calendar days of discharge from an acute psychiatric hospital (Post Hospitalization Outpatient Access – PHOA) and continue RC2 PIP in collaboration with APS/EQRO and Statewide consultants. LACDMH Managed Care Division will implement a new intervention to reduce Inpatient Readmission Rates by having staff conduct site visits to hospitals in order to improve continuity of care as well as reporting discharge data to hospitals and outpatient service providers.

EVALUATION

This goal has been met.

The course of the RC2 PIP, as well as showing the re-hospitalization trends of the LACDMH system, has established fundamental monitoring systems and systemic policy changes in response to collected data. In addition to the use of the STATS Post-Hospitalization Outpatient Service Indicator (PHOA) which monitors access to outpatient service following consumers hospital discharge, now LACDMH provides Inpatient facilities with monthly "Report Cards" in which their performance on the PHOA indicator is reported, as well as alerts regarding possible errors in their data entry process (for example, duplicate consumer entries and data indicating hospitalizations exceeding one (1) year). At this time, LACDMH tracks high-end utilizers in order to develop strategies to efficiently provide for these groups' mental health needs. Other systemic changes include establishing contractual language to ensure Inpatient providers open and close Inpatient episodes within specified timelines. During the APS/CAEQRO Site Review, April 2012, it was determined that this PIP has been completed. (See CAEQRO Report, FY 11-12, pg.38)

VI. MONITORING PROVIDER APPEALS

Goal VI.1.
Continue monitoring the rate of zero appeals through CY 2012.

This goal has been met.

TABLE 37: PROVIDER APPEALS

Level	Day Treatment	TBS Authorization	Network	Total Appeals
2008				
1st and 2nd	0	0	0	0
2009				
1st and 2nd	0	0	0	0
2010				
1st and 2nd	0	0	0	0
2011				
N/A	0	0	0	0
2012				
N/A	0	0	0	0

Note: Levels removed in 2011.

LACDMH has successfully maintained the level of provider appeals at zero. In 2011, the State DMH deleted the requirement for First and Second Level Appeals. Contractors have not filed appeals for Day Treatment and TBS authorizations over the past 5 (five) calendar years, for CY 2008 through CY 2012.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 1: INCREASE ACCESSIBILITY OF SERVICES

Objective 1: Increase the number of Latino consumers served who are estimated with SED and SMI at or below the 200% Federal Poverty Level (FPL) from 42.5% in FY 11-12 to 43.5 in FY 12-13 for CDHCS and from 36.8% to 37.8% in FY 12-13 for CHIS.

Population: Latino Persons estimated with SED and SMI at or below 200% FPL

Indicator: Number of Latino persons receiving services

Measure: Unduplicated number of persons served by ethnicity at or below 200% FPL **/** By County population estimated with SED and SMI by ethnicity at or below 200% FPL

Source(s) of Information:
1. Prevalence: California Health Interview Survey (CHIS)
2. Consumers Served: LACDMH Integrated System (IS)
3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau

Significance: Treated prevalence rates are called Penetration Rates. Penetration Rates indicate the ability to identify persons in need of mental health services and the responsiveness of the service delivery system to provide these services. Penetration Rates serve as a general measure of accessibility to needed services by persons who need them. Actual service utilization by identified target populations and the use of mental health epidemiology data is a national measure for monitoring accessibility. In addition to using this data to assist in identifying disparities, it can be useful in setting goals for improvement.

Prevalence Rate Estimated Statewide for Latino living at or below 200% FPL: 7.6% in 2009.

Penetration Rates in the County for Latinos living at or below 200% FPL by trend data: 41.4% in FY 08-09, 41.1% in FY 09-10, 38.2% in FY 10-11, and 40.3% in FY 11-12.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 1: INCREASE ACCESSIBILITY OF SERVICES

Objective 2: Increase the number of Asian/Pacific Islander (API) consumers served who are estimated with SED and SMI at or below the 200% Federal Poverty Level (FPL) from 24.3% in FY 11-12 to 25.3% in FY 12-13 for CDHCS and from 21.1% to 22.1% in FY 12-13 for CHIS.

Population: API Persons estimated with SED and SMI at or below 200% FPL

Indicator: Number of API persons receiving services

Measure: Unduplicated number of persons served by ethnicity at or below 200% FPL **/** By County population estimated with SED and SMI by ethnicity at or below 200% FPL

Source(s) of Information:
1. Prevalence: California Health Interview Survey (CHIS)
2. Consumers Served: LACDMH Integrated System (IS)
3. Population Estimates: American Community Survey (ACS), U.S. Census Bureau

Significance: Treated prevalence rates are called Penetration Rates. Penetration Rates indicate the ability to identify persons in need of mental health services and the responsiveness of the service delivery system to provide these services. Penetration Rates serve as a general measure of accessibility to needed services by persons who need them. Actual service utilization by identified target populations and the use of mental health epidemiology data is a national measure for monitoring accessibility. In addition to using this data to assist in identifying disparities, it can be useful in setting goals for improvement.

Prevalence Rate Estimated Statewide for API living at or below 200% FPL: 4.7% in 2009.

Penetration Rates in the County for API living at or below 200% FPL by trend data: 27.4% in FY 08-09, 26.2% in FY 09-10, 23.9% in FY 10-11, and 22.2% in FY 11-12.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 1: INCREASE ACCESSIBILITY OF SERVICES

Objective 3: Increase the percent of Latino consumers retained for 5-15 services from 30.3% to 31.3% and for 16 or more services from 46.8% to 47.8%.

Population: Latino Consumers

Indicator: Number/Percent of Latino Consumers retained for 5-15 and 16 or more services.

Measure: Unduplicated number of consumers by ethnicity retained for 5-15 services and 16 or more / By the total number of consumers served by ethnicity.

Source(s) of Information: LACDMH Integrated System (IS)

Significance: Retention in treatment can indicate the ability of the service delivery system to engage and retain consumers toward the satisfactory completion of treatment. Retention or utilization rates reflect the responsiveness of the service delivery system in engaging consumers in their recovery and wellness. Retention of identified target populations and the use of mental health epidemiology data is a national measure for monitoring accessibility. In addition to using this data to assist in identifying disparities, it can be useful in setting goals for improvement.

Latino Retention Rates in the County: 27.6% for 5-15 services and 48.4% for 16 or more in FY 08-09; 28.7% for 5-15 services and 47.8% for 16 or more in FY 09-10; 32.0% for 5-15 services and 38.8% for 16 or more in FY 10-11; and 30.3% for 5-15 services and 46.8% for 16 or more services in FY 11-12.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 1: INCREASE ACCESSIBILITY OF SERVICES

Objective 4: Increase the percent of Asian/Pacific Islander (API) consumers retained for 5-15 services from 32.5% to 33.5% and for 16 or more services from 48.5% to 49.5%.

Population: Asian/Pacific Islander (API) Consumers

Indicator: Number/Percent of Asian/Pacific Islander (API) Consumers retained for 5-15 and 16 or more services.

Measure: Unduplicated number of consumers by ethnicity retained for 5-15 services and 16 or more / By the total number of consumers served by ethnicity.

Source(s) of Information: LACDMH Integrated System (IS)

Significance: Retention in treatment can indicate the ability of the service delivery system to engage and retain consumers toward the satisfactory completion of treatment. Retention or utilization rates reflect the responsiveness of the service delivery system in engaging consumers in their recovery and wellness. Retention of identified target populations and the use of mental health epidemiology data is a national measure for monitoring accessibility. In addition to using this data to assist in identifying disparities, it can be useful in setting goals for improvement.

API Retention Rates in the County: 30.4% for 5-15 services and 50.6% for 16 or more in FY 08-09; 32.0% for 5-15 services and 50.3% for 16 or more in FY 09-10; 35.0% for 5-15 services and 41.3% for 16 or more in FY 10-11; and 32.5% for 5-15 services and 48.5% for 16 or more in FY 11-12.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN I: MONITORING SERVICE DELIVERY CAPACITY

GOAL 1: INCREASE ACCESSIBILITY OF SERVICES

Objective 5: Continue to provide Service Area Trainings on evaluating data for Quality Improvement to consumers, family members, providers, and other stakeholders at least one time per year.

Population: Countywide consumers, family members, providers and stakeholders

Indicator: Service Area Training

Measure: Number of Service Area Trainings conducted during 2013.

Source(s) of Information: LACDMH Integrated System (IS)

Significance: We are committed to involving consumers, family members, and providers in the evaluation of data to identify barriers to improve clinical practice and the administration of the service delivery system. Trainings are provided at the Departmental Quality Improvement Council meetings as well as in Service Area Quality Improvement Committee meetings in order to support members in using data to assist in identifying disparities and in setting goals for improvement.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 1: ACCESS TO AFTER-HOURS CARE

Objective 1: Maintain access to after-hours care at 70% of Psychiatric Mobile Response Team (PMRT) response time of one hour or less between PMRT acknowledgement of receipt of the call to PMRT arrival on the scene and continue year to year trending of the data.

Population: Consumers of PMRT urgent after-hours care

Indicator: PMRT response time

Measure: The number of after-hour PMRT response times of one hour or less / By the total number of after-hour PMRT responses provided.

Source(s) of Information: LACDMH ACCESS Center

Significance: The ACCESS Center PMRT responsiveness is used as an indicator of timeliness of field visits requiring rapid intervention and assistance. The rationale for this indicator concerns providing alternatives to hospitalization and linkage with other appropriate lower levels of care such as Urgent Care Centers. The response time to urgent field visits is measured in four incremental response time categories, beginning with 45 minutes or less and ending with 91 minutes or more.

PMRT after-hour response rates of one hour or less in the County by annual trend data: 73% in 2008 (3,357 PMRT Responses Provided), 68% in 2009 (3,448 PMRT Responses Provided), 69% in 2010 (3,857 PMRT Responses Provided), 70% in 2011 (4,288 PMRT Responses Provided), and 67% in 2012.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 2: RESPONSIVENESS OF THE 24-HOUR TOLL FREE NUMBER

Objective 1: Maintain the rate of abandoned calls (responsiveness of the 24-hour toll free number) at an overall annual rate of 16% or less.

Population: Consumers using the ACCESS 24/7 Toll Free number: 1-800-854-7771

Indicator: Abandoned Call Rate

Measure: Total number of calls in which caller hung up after 30 seconds / By the Total number of ACCESS Center calls.

Source(s) of Information: LACDMH ACCESS Center

Significance: The ACCESS Center Abandoned Call Rate is used as an indicator of response time to calls received by the 24/7 Toll-Free Telephone Line for mental health services and other referrals as appropriate, including the calls received in non-English languages. This national indicator is also monitored by the LACDMH annual Test-Calls Protocol. The rationale for this indicator concerns providing alternatives to hospitalization and linkage with other appropriate lower levels of care such as Urgent Care Centers. It is also a means of measuring linguistic and cultural accessibility to mental health services.

Abandoned Call Rates in the County by annual trend data: 13% in CY 2008 (275,051 Total Calls), 14% in CY 2009 (283,098 Total Calls), 15% in CY 2010 (295,016 Total Calls), 15% in CY 2011 (304,470 Total Calls), and 21.6% in CY 2012 (253,602 Total Calls).

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 3: CONVENIENT LOCATION OF SERVICES

Objective 1: Maintain percent at 87.1% in 2013 for consumers/families reporting that they are able to receive services at convenient locations and continue year to year trending of the data.

Population: Outpatient Clinic and Day Treatment Program consumers/families

Indicator: Consumers/family members reporting service locations are convenient

Measure: The number of consumers/family members that agree or strongly agree that they are able to receive services at convenient locations / By the total number of consumers/family members that completed the survey during the survey period.

Source(s) of Information:
1. Mental Health Statistics Improvement Program (MHSIP) Consumer Survey-State Performance Outcomes (2007, 2008, 2009 and 2012)
2. County Performance Outcomes Survey (2012)
3. MHSIP data collected from the counties at the State level (2010)

Significance: The consumers' perception of service accessibility indicates ease of access and barriers encountered from the consumer's perspective. The items comprising the Access domain of the MHSIP Consumer Survey are used to obtain a measure of the domain and are based on concerns identified by consumers. This is one item among others from within the Access domain that relates to location of service, frequency of contact, staff responsiveness and the availability of services.

Reported Location of Services was convenient in the County by trend data: 85.6% in FY 07-08, 86.4% in FY 08-09, 87.7% in FY 09-10, and 87.1% in FY 11-12.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN II: MONITORING ACCESSIBILITY OF SERVICES

GOAL 4: CONVENIENT TIMES FOR SERVICES

Objective 1: Maintain percent at 89.7% in 2013 for consumers/families reporting that they are able to receive services at convenient times and continue year to year trending of the data.

Population: Outpatient Clinic and Day Treatment Program consumers/families

Indicator: Consumers/family members reporting services are available at convenient times

Measure: The number of consumers/family members that agree or strongly agree that they are able to receive services at convenient times / By the total number of consumers/family members that completed the survey during the survey period.

Source(s) of Information:
1. Mental Health Statistics Improvement Program (MHSIP) Consumer Survey-State Performance Outcomes (2007, 2008, 2009 and 2012)
2. County Performance Outcomes Survey (2012)
3. MHSIP data collected from the counties at the State level (2010)

Significance: The consumers' perception of access indicates ease of access and barriers encountered from the consumer's perspective. The items comprising the Access domain of the MHSIP Consumer Survey are used to obtain a measure of the domain and are based on concerns identified by consumers. This is one item among others from within the perception of Access domain that relates to location and times of service, frequency of contact, staff responsiveness and the availability of services.

Services were available at times that were convenient in the County by trend data: 88.5% in FY 07-08, 88.5% in FY 08-09, 89.7% in FY 09-10, and 87.1% in FY 11-12.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 1: State Performance Outcomes Survey

Objective 1: Complete the State Performance Outcomes Survey Report for the August 2012 MHSIP Consumer Survey in collaboration with CDHCS and CiMH.

Population: Outpatient Clinic and Day Treatment Program consumers/families

Indicator: MHSIP Survey of consumers/families

Measure: Consumers/family members who agree or strongly agree with MHSIP Performance Outcome Domains/ Total number of consumers/family members who completed the domain questions.

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

Significance: The consumers' perception of general satisfaction, access, quality and appropriateness, participation in treatment planning, perception of outcomes, perception of functioning and perception of social connectedness are a unique perspective of the consumer receiving services. The items comprising the domains of the MHSIP Consumer Survey are used to obtain a measure of each domain as well as overall general satisfaction and are based on concerns identified by consumers.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 2: SENSITIVITY TO CULTURAL/ETHNIC BACKGROUND

Objective 1: Maintain percent at 86.1% CY 2013 for consumers/families reporting that staff were sensitive to cultural/ethnic background and continue year to year trending of the data.

Population: Outpatient Clinic and Day Treatment Program consumers/families

Indicator: Consumers/families reporting sensitivity to cultural/ethnic background

Measure: The number of consumers/family members that agree or strongly agree that staff were sensitive to cultural/ethnic background / By the total number of consumers/family members that completed the survey during the survey period.

Source(s) of Information:
1. Mental Health Statistics Improvement Program (MHSIP) Consumer Survey (2007, 2008, 2009 and 2012)
2. County Performance Outcomes Survey (2012)

Significance: The consumers' perception of quality/appropriateness of services provides the unique perspective of the consumer receiving services. The items comprising the Quality/Appropriateness domain of the MHSIP Consumer Survey are used to obtain a measure of the domain and are based on concerns identified by consumers. This is one item among others from within the perception of Quality/Appropriateness domain that also includes staff belief in recovery, staff sensitivity and respect and information received.

Reported staff was sensitive to cultural/ethnic background in the County by trend data: 88.2% in FY 07-08, 88.6% in FY 08-09, 89.0% in FY 09-10, and 87.1% in FY 11-12.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 3: CONSUMER/FAMILY MEMBER OVERALL SATISFACTION

Objective 1: Maintain percent at 84.4% CY 2013 for consumers/families reporting overall satisfaction with services provided and continue year to year trending of the data.

Population: Outpatient Clinic and Day Treatment Program consumers/families

Indicator: Consumers/families reporting overall satisfaction with services provided

Measure: The number of consumers/family member that agree or strongly agree they are satisfied overall with the services they have received/ By the total number of consumers/family member that completed the survey during the survey period.

Source(s) of Information: Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

Significance: The consumers' perception of quality/appropriateness of services provides the unique perspective of the consumer receiving services. The items comprising the Quality/Appropriateness domain of the MHSIP Consumer Survey are used to obtain a measure of the domain and are based on concerns identified by consumers. This is one item among others from within the perception of Quality/Appropriateness Domain that also includes staff belief in recovery, staff sensitivity and respect and information received.

Reported average satisfaction with services in the County by trend data: 81.7% in FY 07-08, 81.9% in FY 08-09, and 82% in FY 09-10.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 4: Beneficiary Grievances, Appeals and State Fair Hearings

Objective 1: Continue to monitor beneficiary grievances, appeals and State Fair Hearings processes, including year to year trending of the data.

Population: Consumers/family members in the County of Los Angeles

Indicator: Number and type of beneficiary grievances, appeals and State Fair Hearings

Measure: Year to year trending of beneficiary grievances, appeals and State Fair Hearings

Source(s) of Information: Patients Rights Office (PRO) Reports

Significance: LACDMH Beneficiary Problem Resolution Process was established to ensure that a Medi-Cal beneficiary's grievance with the Department is addressed in a sensitive, timely, appropriate, and culturally competent manner. The Patient Rights Office is required to provide a report to the Department of Health Care Services (DHCS) summarizing system-wide grievances and appeals and expedited appeals by type, subject areas established by the Department, and disposition for the prior fiscal year. The Quality Improvement Division is responsible to conduct monitoring activities including but not limited to review of beneficiary grievances, appeals, and fair hearings.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN III: MONITORING BENEFICIARY SATISFACTION

GOAL 5: Requests for Change of Provider

Objective 1: Continue to monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their change of provider request and continue year to year trending of the data.

Population: Consumers/family members in the County of Los Angeles

Indicator: Number and type of Requests for Change of Provider

Measure: Year to year trending of Beneficiary Requests for Change of Provider

Source(s) of Information: Patients Rights Office (PRO) Reports

Significance: LACDMH Policy 200.02, Request for Change of Provider, provides a formal process for consumers to request a change in provider that specifies timeliness for providers to respond to the request, and procedures to follow when reporting such requests to the Patients' Rights Office (PRO). California Code of Regulations specify that, "Whenever feasible and at the request of the beneficiary, the MHP provides an opportunity to change persons providing the Specialty Mental Health Services, including the right to culture-specific providers." The Quality Improvement Division is responsible to conduct monitoring activities including but not limited to review of beneficiary grievances, appeals, and fair hearings.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN IV: MONITORING CLINICAL CARE

GOAL 1: Medication Practices

Objective 1: Continue to improve medication practices through systematic use of medication parameters, medication peer review, and trainings for the use of medication.

Population: Consumers prescribed identified medications

Indicator: Prescribing standards and parameters

Measure: Evaluate using standard and parameter medication practices

Source(s) of Information: Office of the Medical Director (OMD) Reports

Significance: LACDMH Policy 103.01, Standards for Prescribing and Furnishing of Psychoactive Medications, establishes standards for prescribing and furnishing psychoactive medications (hereafter referred to as "medications") in the County of Los Angeles Department of Mental Health and provides a foundation for quality management relating to the use of the major classes of psychoactive medications. The Quality Improvement Division conducts ongoing monitoring activities of relevant clinical issues, including the safety and effectiveness of medication practices and the interventions implemented when occurrences of potential poor care are identified.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN V: MONITORING THE CONTINUITY OF CARE

GOAL 1: Client Flow

Objective 1: Initiate a Quality Improvement Project in Service Area 4 for piloting a web based client flow e-tool.

Population: SA 4 consumers/family members

Indicator: Number of vacancies filled

Measure: Daily Reports that show number of available and filled slots in each provider location in SA 4.

Source(s) of Information: Service Area 4 Data Reports

Significance: The Service Area 4 administration has initiated a project on improving client flow and filling slots for mental health services among providers serving consumers in the Service Area. A website has been developed that allows providers to enter the number of available slots for services at their agency. Other providers are able to view this information and refer consumers to appropriate services based on their availability. The availability of information includes language capacity at each provider location. This is expected to improve culturally competent services while appropriately utilizing available resources. This information will be refreshed in real-time and providers will have the most updated information for referring clients. A reporting system has been developed that will allow administrators to track daily reports on the availability and filling of available services in the Service Area. A mapping service and a link to public transportation has been added to the website that will allow providers to assess the geographic feasibility of referring clients to a provider location that is most convenient for them based on the location's accessibility via public transportation.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - QUALITY IMPROVEMENT DIVISION

QI WORK PLAN FOR 2013 - OUTCOME MEASURE DESCRIPTION

DOMAIN VI: MONITORING PROVIDER APPEALS

GOAL 1: Provider Appeals

Objective 1: Continue monitoring the rate of zero appeals through CY 2013.

Population: Contracted Providers

Indicator: Provider Appeals

Measure: Provider Appeals by program and type of service.

Source(s) of Information: LACDMH Managed Care Division

Significance: LACDMH monitors the effectiveness of the service approval and non-approval processes for contracted providers for selected services.